PHM/SR9-54 (RB 4)

1284

THE PEOPLE´S HEALTH MOVEMENT

EVALUATION REPORT 2011

December 2011

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ACKNOWLEDGMENTS

Global Health Governance, the Reform of the World Health Organization, Financial Crisis and Crucial Questions on the Social Determinants of Health all contribute to the urgency to clear the way forward for the Peoples' Health Movement. The evaluation team is grateful to PHM leadership to have initiated this evaluation on country-, regional-, and global level. We thank also the steering committee for guidance in crucial issues. Many people world-wide gave their time and ideas on current priority issues in people's health which are reflected in the report and in the recommendations. The findings of this evaluation confirmed that Health for All remains an ever urgent issue world-wide.

PHM Evaluation Team 2011

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ABBREVIATIONS

AIDC	Alternative Information and Development Centre
ANC	African National Congress
APROCSAL	La Asociación de Promotores Comunales Salvadoreños
ARVs	Antiretroviral drugs
ASEAN	Association of Southeast Asian Nations
ASECSA	Asociación de Servicios Comunitarios de Salud
ACHAN	Asian Community Health Action Network
AHED	Association for Health and Environmental Development
CISAS	Centro de Información y Servicios de Asesoría en Salud
CoCo	Coordinating Committee
CHC	Community Health Cell
COSATU	Congress of South African Trade Unions
CI	Consumers International
COSALUP	Colectivo de Salud Popular, Inc
DHF	Dag Hammarskjold Foundation
EAPSEC	Equipo de Apoyo en Salud y Educación Comunitaria
EC	Equipo Comunicándonos
EB	Executive Board
GEGA	Global Equity Gauge Alliance
GHG	Global Health Governance
GHW	Global Health Watch
GK	Gonoshasthaya Kendra
HAI-AP	Health Action International Asia- Pacific
HAI	Health Action International
HfA	Health for All
HiAP	Health in All Policies
IMF	International Monetary Fund
IPHC	International People's Health Council
IPHU	International People's Health University
JSA	Jan Swasthya Abhiyan
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
M&E	Monitoring and Evaluation
MoU	Memorandums of understanding
MSP-LA	Movimiento para la Salud de los Pueblos-Latino America
NCC	National Coordination Committee
NEHAWU	National Education, Health and Allied Workers' Union
NGO	Non-Governmental Organization
PHM	People's Health Movement
PHA	People´s Health Assembly
PHC	Primary Health Care
RTH	Right to Health
SAARC	South Asian Association for Regional Cooperation
SAMWU	South African Municipal Workers' Union
SJC	Social Justice Coalition
SA	South Africa
SC	Steering Council
TWN	Third World Network
TWRF	Third World Relief Fund
ToR	Terms of Reference
TAC	Treatment Action Campaign
TRIPS	Trade-Related aspects of Intellectual Property Rights
UK	United Kingdom

UNDP	United Nations Development Programme
US	United States
WHO	World Health Organization
WGNRR	Women's Global Network for Reproductive Rights
WHA	World Health Assembly
WHR	World Health Report
WSF	World Social Forum
WTO	World Trade Organization

EXECUTIVE SUMMARY

The People's Health Movement (PHM) is a global movement and network that unites health activists, organisations, and academic institutions from around the world in its aim to achieve 'health for all'. PHM has a presence in around 70 countries. The People's Charter for Health, endorsed by the participants of the first People's Health Assembly in Savar in 2000, constitutes the core principles, vision, and mission of PHM. The Charter defines health as a social, economic, and political issue and emphasizes health as a fundamental human right. In order to fulfil this vision, the Charter calls for action at grassroots, national, and international levels and in all sectors.

The goal of the evaluation

The PHM Steering Council agreed in 2010 to conduct this external evaluation of PHM to increase its effectiveness as a global actor for change in support of the right to health. In order to identify gaps and opportunities, and to learn from mistakes and successes that lead to recommendations about PHM's functioning, the evaluation was set out to focus on the following questions:

1. Do the current strategic objectives of the 'organizational component' of the movement adequately respond to the movement's mission articulated by the People's Charter for Health and other strategic documents?
2. To which extent have the current PHM global programs, thematic circles, and other activities achieved the strategic objectives and respond to the PHM mission?
3. To which extent has the current governance structure (including the management system and financial controls) enabled the movement to achieve reasonable levels of inclusiveness and transparency?
4. How effective is the current PHM strategies for managing the sustainability of human and financial resources?
5. Is the current geographical spread pertinent to carrying out the PHM mission?
6. To which extent is the PHM recognized as a global actor for change?

In addition gender is addressed as a key cross cutting issue in all areas covered by evaluation.

The evaluation process

The evaluation was conducted from January to June 2011. It was conducted by a team consisting of six members residing in India, Mexico, South Africa, Switzerland, Sweden, and Thailand. Between them they had experience working for international health agencies, non-governmental organizations, and universities in areas of public health, gender and indigenous populations.

The team used a mix of data sources and tools. Three main sources of data were used: 1) **Document review,** PHM global documents and previous evaluations were initially made available to the team. Regional and local PHM reports, publications, websites, and other relevant documents were then reviewed throughout the evaluation.

2) **Interviews,** Interviews were conducted throughout the evaluation. Face to face interviews were carried out in Geneva, Ecuador, Sri Lanka, South Africa, Thailand, Sweden and England. Skype interviews were conducted with Steering Council members, country representatives and informants; founding members, IPHU alumni and faculty.
3) **Electronic survey questionnaires** (in English and Spanish) were sent out to all to country focal points and representatives. A questionnaire was also sent to IPHU alumni and faculty.

The evaluation was set out to be comprehensive but it is recognized that detailed information often are lacking. Emphasis has been given to indentify overall patterns and characteristics of PHM with corresponding recommendations.

Evaluation findings

1. Do the current strategic objectives of the 'organizational component' of the movement adequately respond to the movement's mission articulated by the People´s Charter for Health and other strategic documents?

PHM has over the past years increased its reach and visibility and has become a unifying movement for many concerned with the 'Right to Health' and 'Health as a Human Right'. PHM has also contributed to the renewal of the thinking around 'Health for All' including the relevance of social determinants to health. The People's Charter for Health sets out an alternative set of values to the neo-liberal view of the world and calls on action on many fronts. As such it carries a strong symbolic value. Some would like to see PHM taking on more or different issues than it has been so far, but there is a lack of strategy and clarity on how to bring diverse topics under the PHM umbrella

Local and national PHM activists do not feel their voice is heard much at the global level, and not everyone sees the relevance of putting too much effort into the global level advocacy. Local and global PHM advocacy initiatives currently seem to lack interconnectedness.

2. To which extent have the current PHM global programs, thematic circles, and other activities achieved the strategic objectives and respond to the PHM mission?

Over the past years the movement has had a number of global campaigns and programmes, such as the Right to Health Campaign, the International People´s Health University (IPHU), the Global Health Watch, and the WHO Watch. These programmes have raised the profile of PHM and its visibility in the international arena. The Right to Health Campaign and IPHU have reached out to new people and groups and been strong vehicles for the dissemination of knowledge and formation and build capacity of young and new activists. However there is a lack of long-term planning and follow-up for those interested in PHM. The Global Health Watch receives strong appreciation from international activists, academics and government officials.
Thematic circles seem to have functioned less well. Some previous thematic circles have gone through some adjustments and are now considered global programmes, like WHO Watch. PHM also partners with the World Social Forum in the vision that

'another world is possible'. Communication tools like the PHM-Exchange and PHM websites play an important role in sharing information and supporting networking.

Many global programmes incorporate some gender analysis but many participants would like to see this come out much stronger.

3. To which extent has the current governance structure (including the management system and financial controls) enabled the movement to achieve reasonable levels of inclusiveness and transparency?

A small group of committed individuals – most of them on a volunteer basis - has put in enormous efforts over the years to support the movement at a global level. These individuals come from diverse backgrounds and different regions but they are united by the core values of the PHM. There is overall agreement within the Steering Council that it is not functioning optimally. The lack of accountability and lack of enforcement of a term limit allows people who are not actually participating in the SC to stay in the Steering Council (SC). Limited and ineffective communication within the SC, between the SC and the Coordinating Committee (CoCo), and the rest of the PHM (including Country Focal Persons) leads to misunderstandings, under appreciation and lack of transparency within the movement.

There is recognition within the Movement of there being a generation gap in the leadership, and a need to include more women and marginalized groups in the leadership of PHM. Although it is crucial that the existing action plan for a new governance structure is implemented as planned leading up to the People's Health Assembly in 2012 (PHA3) further discussions on how to actively involve women and marginalized groups in the leadership is needed..

The current three Global Secretariats are well coordinated and many within PHM appreciate the new structure. Concerns have however been raised repeatedly from Latin America that they would like to see a Global Secretariat hosted in their region. Financial controls and transparency have greatly improved in recent years

4. How effective are the current PHM strategies for managing the sustainability of human and financial resources?

PHM is very effective in piggybacking on other events and in its use of resources. The number of paid staff is kept to a minimum. However the lack of regional administrative coordinators is making the management of human resources less than optimal. Most of the programmes as well as the PHM-Exchange depend heavily on just one or two PHM members, which is a risk factor and a lost opportunity to get more PHM members involved.

IPHU has been one of PHM´s most important activities in the last years, but the lack of follow -up and concrete opportunities for alumni to get involved in PHM make it not achieve its potential in recruiting active members. A notable exception is the African regions which has had the financial resources for a designated person to coordinate follow-up activities. Similar results are expected in other regions if resources were available.

There is need for more clarity in terms of who raises funds for what. At both regional and national levels there are expectations as well as uncertainties over the role of fundraising from PHM global. Although there is strong appreciation for volunteer work and it is considered normal that members of the movement should contribute something to joint meetings and activities throughout the network, lack of funding is considered a challenge across the board. Changes in donor priorities and economic crises which decrease development funds that are made available pose real threats to the longer term financial sustainability of the network.

5. Is the current geographical spread pertinent to carrying out the PHM mission?

PHM has a presence in all regions of the world. Many of those active in PHM work at the grass roots and PHM is therefore able to represent grass roots community health movement. There is, however, still considerable potential to develop global links between grass roots health movements. The 'presence' in countries is not always at grass roots levels but can also be concentrated on academics. Regional coordination is lacking in most regions and there is a lack of planning. Language forms an obstacle for communication between regions, between countries and also within countries. The digital divide is an important consideration when aiming to bring out the voices of the poor and marginalized, especially since much of PHMs international and even national work relies heavily on online communication.

India and Latin America seem to be the strongest regions, although a decline in activities has been reported from India. Latin America has functioned quite independently from PHM in other regions and at the global level. The movement in Africa is young and less established, but growing.

In other regions the movement is patchy and is often represented by a few dedicated individuals who have direct contact with the global level.

6. To which extent is the PHM recognized as a global actor for change?

PHM has a genuinely good reputation globally in the spaces where it is active. The messages 'resonate'. PHM is known for its influence in the WHO Commission of Social Determinants and presence at the World Health Assemblies. The Global Health Watch is well recognized with WHO, health NGOs and some governments. Various other PHM publications, as well as its articles in publications like the Lancet, contribute to the visibility of PHM and the promotion of the message of 'Health for All'. PHMs analysis and health activism is also increasingly incorporated into medical and health education and taken up by lecturers and students.

However, global activities are not always grounded at a local level and the balance between 'global' and 'local' (or grass roots) needs to be better managed.

Suggestions and recommendations

The following are suggestions which the evaluation team believes will strengthen PHM´s impact as a global actor for change. Many of these recommendations come from within the Movement and have been shared during the process of this evaluation by PHM members across the globe.

- **To increase the breadth and depth of PHM as a movement and strengthen its internal diversity.** To embrace diversity is essential for ensuring a credibility as well as sustainability. Globally, this means identifying ways to better represent the diversity of the movement in its governance structures, priorities, campaigns and working groups. In the regions it involves increasing outreach to other movements, activists and academics who share PHM core values and vision, and who can develop other activities which are not seen as priorities by current PHM members. Concrete activities that bring together different countries and regions would naturally bring different strands of PHM together. It is important to consciously guard against sectarianism and exclusivism. IPHUs have a great potential to support movement building by providing courses focusing on collective activism and advocacy.

- **The governance structures – from the Steering Council (SC) to the state and district level coordination committees should be reviewed.** It is essential to keep the secretariat functions and ensure the capacity for strategic fundraising. The governance processes and representation should however be more inclusive and transparent. A system of 'mentoring' or 'coaching' could provide opportunities for newer and younger PHM members to be active while still receiving support from more experienced members.

- **The Gender Committee that that was established in 2010 by the Steering Council should develop an action plan towards strengthening gendered perspectives and inclusion of marginalized issues and concerns.** While some of this is happening, a stock taking of PHM initiatives that provide spaces for this and potential ways should be assessed.

- **To strengthen participatory strategic development and planning.** Prioritizing strategies and actions (campaigns, programmes, IPHUs etc) at national and regional levels will be useful, along with processes to decide if and what role the PHM can play in other campaigns. Interested IPHU alumni (and other new recruits) need to be offered concrete projects and campaigns to get involved in to make their participation in PHM active, meaningful and enduring. The African region has positive experiences of such involvement facilitated by the African regional coordinator.

- **Regional SC representatives need to be (s)elected and have support from staff** to work on outreach, networking and communication to support planning and activities including fundraising. A system is underway to make the (s)election of Regional SC representatives more participatory, inclusive and transparent. Organizing Regional PHAs could contribute to Movement building and solidarity.

- **Environment and health**: PHM is well placed (both geographically and in composition) to carry out in depth, far-reaching research, awareness-building, campaigning, advocacy and social mobilising to curb devastating effects on the health of people, communities and environment of climate change and open pit mining and other transnational 'mega projects'..

- **Communication strategies for improved transparency.** Regular condensed meeting minutes from CoCo and SC should be made available with the possibility for anyone to add their ideas and opinion. Information about the PHM – Charter / principles, activities, structure, functioning, etc. should be disseminated widely and made easily available both electronically and in other ways.

- **Communication strategies for improved networking.** In order to improve PHM communication within the network and with interested 'outsiders' a list serve could be established in which people can select their areas of interest. Thematic discussions could be initiated through separate email groups, small skype sessions or an internet discussion forum. It is recommended to create a PHM Global Communications Committee hosted in Latin America, which In collaboration with the existing web team could enhance greater coordination regionally and in PHM globally through technological and electronic means.

- **Develop local strategies for influencing WHO and global health governance.** The new PHM initiative of WHO Watchers is promising. PHM should increase emphasis on country circles (in its broadest definition) and lobbying with WHO country representatives as well as Ministries of Health.

- **Permanent PHM presence in Geneva (WHO Secretariat) would greatly facilitate WHO lobby.**. PHM today is reactive in most policy debates, while Primary Health Care and 'Health for All' were radically modern and proactive issues. It is therefore recommended to PHM to establish some kind of "think tank" as permanent observer of selected priority policy themes. This should be considered a long term goal given the current financial situation of PHM

CHAPTER 1: INTRODUCTION TO PHM

The People's Health Movement (PHM) is a global movement and network that unites health activists, organisations, and academic institutions from around the world in its aim to achieve 'health for all'. PHM has a presence in around 70 countries.

1.1 Brief history

PHM is one of the outcomes of the People's Health Assembly that took place in Savar, Bangladesh, in 2000. The People's Health Assembly was a unique gathering of nearly 1,500 health activists and academics from around the world with the aim to re-establish health and equitable development as top priorities in local, national and international policy-making. The assembly brought out the "voices of the unheard"[1] and reiterated the continued relevance and importance of the Alma Ata Declaration from 1978 which calls for "health for all" through a Primary Health Care (PHC) approach.

Eight networks and organisations[2] joined hands to organize this first People's Health Assembly, and took a leadership role – together with some additional individuals and organisations – to coordinate and support follow up of the Assembly by promoting its outcome document and action plan: the People's Charter for Health[3].

1.2 Principles, vision, mission

The People's Charter for Health, endorsed by the participants of the first People's Health Assembly in Savar in 2000, constitutes the core principles, vision, and mission of PHM.

The Charter defines health as a social, economic, and political issue and reafirms health as a fundamental human right. It envisions "a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives"[4]. In order to fulfil this vision, the Charter calls for action at grassroots, national, and international levels and in all sectors.

Over the years, additional 'people's

The significance of the global **People's Charter for Health** is multiple:

- it endorses health as a social, economic and political issue and a fundamental human right;
- it identifies inequality, poverty, exploitation, violence and injustice as the roots of preventable ill-health;
- it underlines the imperative that 'Health for All' means challenging powerful economic interests, opposing globalization as the current iniquitous development model; it thus drastically changes our political and economic priorities;
- it brings in a new perspective and the voices from the poor and the marginalized, encouraging people to develop their own local solutions; and
- it encourages people to hold accountable their local authorities, national governments, international organizations and national and transnational corporations.

[source: www.phmovement.org]

[1] See PHM Evaluation 2004 for more information.
[2] The eight founding networks and organizations of PHM are: Asian Community Health Action Network (ACHAN); Consumers International (CI); Dag Hammarskjold Foundation (DHF); Gonoshasthaya Kendra (GK); Health Action International (HAI); International People's Health Council (IPHC); Third World Network (TWN); Women's Global Network for Reproductive Rights (WGNRR).
[3] The People's Charter for Health is commonly referred to as the People's Health Charter.
[4] People's Charter for Health, p2-3.

declarations' have been developed that provide further detail of PHM's vision and mission[5] including:

- Mumbai Declaration (2004)
- People's Charter on HIV and AIDS (2004)
- Cuenca Declaration (2005).

More recently, PHM's commitment to address the social determinants of health – especially current economic structures that lead to growing inequity within and between nations - is explicitly added to PHM's mission statement, reflecting PHM's contribution over the years to global discussions on social determinants of health.

There are also more localized PHM declarations, such as the Indian Women's Health Charter from 2007 that can guide the movement locally, nationally or regionally.

1.3. Financial resources and expenditures

There is massive contribution to the movement provided by individuals giving their time on voluntary basis and in-kind contribution by PHM partners.

Since the beginning of the movement there has been constant struggle for fund raising. The economic crisis has made this task even more challenging. PHM Global has since mid 2006 been able to raise 1.3 million Euros for activities that are centrally coordinated. Oxfam-Novib (the Netherlands) has been the biggest financial supporter during the last years[6].However Oxfam-Novib has decided 2011-2012 to be the exit grant as health is no longer a priority for its global programme. This decision is of great concern to the movement which runs already on a very limited budget.

Fifty-six % of the total expenditures managed by the global secretariat went to the PHM central activities and global programs; namely the International People's Health University, Global Health Watch, Democratizing Global Health Governance Initiative, Supporting regional and country-based activities within the framework of the Right to Health Campaign, lobbying activities within health policy-related events, etc.

The IPHU consumed 33% of the total expenditures to organize 18 2-week training course for health activists that accommodated more than 800 participants with average cost of EUR 450 per participants. The expenditures on regional and country based processes represented 6%, however, most of the funds spend on global activities are aimed at building the capacity at country level, especially within the framework of IPHU.

The institutional costs (including secretariat staff) represented 29% of the total expenditures. These funds were used to run three secretariat offices in three countries with an average cost of EUR 1,789 per office per month.

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[5] According to PHM's website, www.phmovement.org (accessed 10 January 2011).

[6] Other significant funders since mid 2006 include Interchurch Organisation for Development Cooperation (ICCO , The Netherlands), Medico International (Germany), the Rockfeller Foundation (USA), Cordaid (The Netherlands), Diakonie, Misereor and Save the children (UK), Health System Trust, World Council of Churches.

CHAPTER 2: EVALUATION OBJECTIVES AND METHODOLOGY

The PHM Steering Council agreed in 2010 to conduct this external evaluation of PHM to increase its effectiveness as a global actor for change in support of the right to health. It was supported by Oxfam/Novib and conducted by an independent team of consultants with diverse background and based in different regions.

The overall goal of the evaluation is to enable sharper impact of the PHM as a global actor for change.

2.1 Evaluation objectives

In order to identify gaps and opportunities, and to learn from mistakes and successes that lead to recommendations about PHM's functioning, the evaluation is expected to address the following questions (see the complete Terms of Reference (ToR) in Appendix 1):

1. Do the current strategic objectives of the 'organizational component' of the movement adequately respond to the movement's mission articulated by the People's Charter for Health and other strategic documents?
2. To which extent have the current PHM global programs, thematic circles, and other activities achieved the strategic objectives and respond to the PHM mission?
3. To which extent has the current governance structure (including the management system and financial controls) enabled the movement to achieve reasonable levels of inclusiveness and transparency?
4. How effective is the current PHM strategies for managing the sustainability of human and financial resources?
5. Is the current geographical spread pertinent to carrying out the PHM mission?
6. To which extent is the PHM recognized as a global actor for change?

Gender is a key cross cutting issue that is addressed specifically in chapter 8 and reviewed in all areas covered by this evaluation.

2.2 Scope of the evaluation

This evaluation builds onto the lessons learned and recommendations shared in previous PHM evaluations (see chapter 3). The scope of the evaluation is broad in that it aims to address internal strategies and processes as well as external relevance and impact and takes account of global, regional and country levels (through selected case studies). This evaluation is focused on 'local vs. global' issues and the strategic directional dynamics in this respect within PHM, seen as the major issue today, when Health for All (HfA) is considered. Raising the issue of 'impact', 'effectiveness' and 'efficacy' of 'activism' on global level, the report concentrates more on the mode of activism, rather than specific programme and/or -policy issues. This seems very much in context with the ToRs of the mission, since both governance issues and health coverage are two central issues to the "Charter" of PHM.

The evaluation therefore does not pretend to cover all geographical regions and activities. We chose to further explore Latin America and Asia where activities have been longstanding, and Africa where recent effort has been made for increased

mobilization. Country case studies were selected to represent interesting and diverse experiences from different regions, in addition to being logistically feasible. The countries included in this report are:

- India – with a long PHM history and well-known PHM organization;
- Sri Lanka - for its successful movement building despite conflicts;
- Ecuador – having hosted PHA II; and
- Thailand - for its interest in PHM without active participation in PHM.

It is recognized that other countries would be equally good choices.

Activities are exemplified by the lobbying work at the World Health Organisation (WHO) and the International People´s Health University as they represent two of the prioritized activities to sharpen the global impact of PHM in recent years.

There is a general consensus in literature[7] that the main purposes for evaluation of networks are:

1. Learning (from/about success and failure)
2. Future planning and strategizing (and propose solutions to problems)
3. Accountability
4. Consolidation of networks / register achievements and impacts
5. Preserving institutional memory

The evaluation team aims for this report to contribute to all of these purposes.

2.3 Evaluation team and process

The evaluation was conducted from January to June 2011. It was conducted by a team consisting of six members with diverse backgrounds residing in India, Mexico, South Africa, Switzerland, Sweden, and Thailand. Between them they had experience working for international health agencies, non-governmental organizations, and universities in areas of public health, gender and indigenous populations.

All evaluation team members had some prior knowledge of or experience with PHM. All were at the time of the evaluation sympathetic to PHM but not actively involved. This position was clarified during the evaluation:

> *While discussion partners in WHO sometimes requested to know the position the evaluator takes´ vis-à-vis certain critical issues (i.e. is the evaluator "sympathetic" to PHM and/or WHO), I clarified my role as an independent evaluator, whose task it is to look into PHM's role, effectiveness, efficiency and impact with regard to policy positions on global health policy level, including, of course Equity and Social Determinants issues, in line with the Health Charter of PHM as guiding basic document. [JK]*

During the evaluation the evaluation team was in contact with a reference group from PHM consisting of the Global Coordinator and three representatives from the

[7] Including Karl, M [Editor]. Measuring the Immeasurable: Planning, Monitoring and Evaluation of Networks. WFS, 1999; Nunez M and Wilson-Grau R. Towards a conceptual framework for evaluating international social change networks, 2003.

Steering Council. PHM Secretariat facilitated contacts through provision of a list of potential discussion partners and contact details. Each member of the evaluation team was provided with and an introduction letter to be shared with interviewees.

The evaluation team did not at any time during the evaluation meet face-to face but relied on Skype meetings and e-mail communication, requiring a detailed division of labor. The evaluation was divided into the following components per team member, based on their PHM experience, expertise and/or location.

Team member	PHM experience	Core evaluation components/ responsibility
Anna-Karin Hurtig (AH)	People's Health Assembly II (PHA II)	- Overall coordination - Global governance - Founding networks - International People´s Health University [8]. - European Region - Australia and Pacific
Deepa Venkatachalam (DV)	Actively involved in an NGO with strong PHM links	- India and other selected country cases in Asia - Regional coordination in Asia - Global secretariat office in Delhi - Special resource on gender and local governance
Joachim Kreysler (JK)	Involved since 2005 in discussions with WHO Watch, and as WHO staff	- Thematic circles (WHO, Global Health Watch) - Special focus on the global impact
Louis Reynolds (LR)	Founding member PHM South Africa	- Selected country cases in the African region - Regional coordination in Africa - Global Secretarial office Cape town
Morna Macleod (MM)	Conducted the evaluation of PHM Latin America in 2010	- The Americas - Case study Ecuador - Regional coordination in the Americas - Special resource on gender, cultural diversity and organizational strengthening
Nadia van der Linde (NL)	PHA II Served on the Steering Council (2003-2005)	- Global governance structures - Founding networks - Case study Thailand - Special resource on gender - Support final report writing

2.4 Data collection sources and tools

The team used a mix of data sources and tools. The overall design of the evaluation was agreed on at the initial phase. The design allowed for a flexible data collection appropriate to the context (Appendices 2 and 3). Logistics also determined sources and tools used.

Three main sources of data were used:

Document review

PHM global documents and previous evaluations were initially made available to the team. Regional and local PHM reports, publications, websites, and other relevant documents were then reviewed throughout the evaluation.

Interviews

[8] AH gratefully acknowledge the excellent support from Kjerstin Dahlblom at Umea Unviersity, Sweden in the evaluation of the IPHU including the electronic surveys.

Interviews were conducted throughout the evaluation. Face to face interviews were carried out during field visits in Ecuador, Sri Lanka and India (approximately 15 interviews at each site) as well as a few face to face interviews in South Africa, Thailand, Sweden and England. Thirty-six interviews were conducted with WHO's secretariat, regional and country staff, as well as with the 2011 WHO Watchers and health staff in the World Council of Churches. In addition brief discussions were held with a large number of delegates to the World Health Assembly 64 and Executive Board 128/9.
Face to face interviews were also conducted with the global coordinator and two members of the coordinating council on a visit to Bangkok. Skype interviews were conducted with Steering Council members, country representatives and informants; founding members, IPHU alumni and faculty (approximately 25 such interviews were conducted).

Electronic survey questionnaires
Electronic survey questionnaires (in English and Spanish) were sent out to all to country focal points and representatives (Appendix 4). Ninety questionnaires were sent and 36 were returned. A questionnaire was also sent to IPHU alumni and faculty (Appendix 5). Six hundred sixty five questionnaires were sent and 116 were returned. A summary of quantitative survey results are presented in appendices 6-7.

2.5 Confidentiality

Many of the informants wanted to be sure of the confidentiality during the interviews. Therefore names are only mentioned when the interviewee clearly has stated that they did not mind their name appearing. In other cases statements and opinions have been written in such a way that it should not be possible to trace the source. We have also not included personalized critique.

Drafts of parts of the reports were shared and discussed with regional and global PHM representatives during the process. All members of the steering council were given the opportunity to give feedback on the report before the final version was completed. Their feedback served to check accuracy and improve clarity but not to change conclusions drawn during the evaluation.

2.6 Limitations

The evaluation team worked with limited resources. It should be noted, that this evaluation is unusual when measured against current international standards in evaluation, in that the team never met and as a consequence objectives and approaches could not be completely fine-tuned. In such a basic and at the same time complex enterprise, 'skyping' simply cannot replace personal contact and eye-to-eye exchange of views.

The team members were contracted for on an approximate of 20 days of work each during the evaluation period. The time constraints made it impossible to do more than a few case studies at country and regional levels. The electronic questionnaires tried to make up for that to some extent, but both the relatively low response rate as well as the nature of the data make the evaluation of geographical spread of PHM patchy. Language barriers were another limitation. The electronic questionnaires were only available in English and Spanish. It was decided to not to include all the responses

from the surveys in the main report but to use them as a complement and reference, all the findings were made available to the PHM Steering Council.

Some of the respondents from within PHM had not heard about the evaluation till they had received an email or telephone call in this regard (from the evaluation team member) and some of them wondered why they had not heard from the Global Secretariat directly. They commented on the communication patterns and felt that these were inadequate and delayed. They were curious about the motivation for the evaluation and process of selection of the evaluation team. A few drew parallels with this later, stating how the functioning of the PHM could be more transparent and facilitate better dissemination of information.

The past experiences of the evaluators enabled them to collect data and get in contact with key informants during a relatively short time. Key informants were interviewed from within but also from outside of PHM. The evaluation was set out to be comprehensive but it is recognized that detailed information often are lacking. Emphasis has been given to indentify overall patterns and characteristics of PHM with corresponding recommendations.

CHAPTER 3: PREVIOUS EVALUATIONS

PHM has conducted one earlier external evaluation of the overall movement/network, in 2004, and several more recent evaluations (internal and external) more of specific aspects or regions of the network:

- Evaluation of PHM in Latin America (July 2010);
- PHM Website Audit (August 2010); and
- Right to Health Campaign Assessment (October 2010).

In addition, regular reviews of PHM's structures, communication and activities takes place within the Steering Council (SC) and Coordinating Committee (CoCo). Detailed internal reviews were conducted by Steering Council members in preparation for the August 2010 Steering Council meeting. These very informative reports and subsequent internal discussions address the functioning of Country Circles, Gender, IPHU, Right to Health Campaign (RTH), Global Health Governance, Global Health Watch, PHA III, the governance structure, and several regional overviews.

This 2011 evaluation of PHM aims to build on these previous findings and lessons learnt and avoid overlap as much as possible.

3.1 Evaluation of PHA and the initial years of PHM development 2004

"*Keeping the Promise: The People's Response to Health for All. An Evaluation Report of the Process that Led to the People's Health Assembly 2000 and the Development of the People's Health Movement*", November 2004, by Exchange.

This evaluation, led by Andrew Chetley of Exchange and supported by a larger evaluation group, involved a three-year participatory process that aimed to assess and at the same time help build the movement. The main questions or 'indicators of change' used in the evaluation are:

- Has there been enhanced cooperation among key individuals and organisations active in public health?
- Have people most at risk from poor health conditions played an active and central role in the planning, development, leadership, and governance of the PHM?
- Has the PHM enabled dialogue and discussion at various levels and in different arenas to encourage change in policies and practices affecting people's health?
- Has the PHM evolved effective internal and external communication strategies to ensure active participation, inclusion, and impact?
- Is the PHM an appropriate platform for facilitating the voices of the unheard to be heard?

The report highlights that the development of PHM after People´s Health Assembly (PHA) had a slow start as the organisers of the Assembly, although always intending the Assembly to be part of a process and not a stand-alone meeting, had focused on the preparatory processes and meeting itself more than its follow-up.

Main weaknesses and strengths of PHM identified in 2004:

Weaknesses	Strengths
- Lack of strategic planning and communication - Underrepresentation of Africa - Lack of finances - Lack of transparent decision making	- Built bottom up, reflecting people's realities and concerns (or the 'voices of the unheard'); - Multi-sectoral movement, linking diverse groups and people covering different thematic areas linked together

The main lessons learnt from the evaluation process can be summarized as follows:

- Improve internal and external communication and information sharing;
- Conduct review and reflection processes;
- Develop a strategic plan;
- Improve documentation of activities;
- Improve transparency of how activities are funded;
- Prioritize and select key areas for action.

Overall, the evaluators consider PHM in 2004 to be a "young, strong and growing movement. One that is drawing on a wealth of wisdom, knowledge, and experience from around the world, and one that offers hope that social change to improve people's health can become more of a reality" (p. 29).

3.2 Evaluation of PHM in Latin America

"*Informe de Evaluación*", July 2010, by Morna Macleod (available in Spanish only).

This independent mid-term review of the 'Red por el Derecho a la Salud en Latino América' [Right to Health in Latin America] project of the 'Movimiento para la Salud the los Pueblos-Latino America' (MSP-LA) [People's Health Movement Latin America] was conducted in 2010 at request of the Third World Relief Fund. The main objectives for the review were to learn lessons and be able to make required adjustments to the project's second phase planning and implementation. The focus of the review was more on the processes and dynamics than on the merely the achieved results.

The report concludes that MSP-LA has clear strengths and relevance in its strategies and messages in relation to health (in its comprehensive and holistic understanding including rights, social determinants, environment, etc). They provide a space for exchange of information, ideas and analysis. The review highlights that the project manages to do much with few resources. The logical framework has not been helpful in the project as it is a challenge to fit broader social change processes into strict planning. Proper M&E mechanisms have not been developed or implemented yet. For example, the MSP-LA website is regularly updated with new materials, including video and audio materials. What is missing is a mechanism to measure the extent to which these materials are actually being accessed and used (and how to improve their use).

The core group of MSP-LA seems to function and communicate well together, the challenge is to expand this core group and allow new people to join.

Recommendations focus on: strengthening the internal planning and communication strategies of MSP-LA; outreach and leadership building; strengthening capacities in logframes and M & E; and ensuring follow-up. It is suggested to separate the technical aspects of the project from the political work of MSP-LA.

3.3 Evaluation of the PHM website

"*People's Health Movement Website Audit*", August 2010, by Chocolate Lily Web Projects.

The PHM website audit was conducted by an external bureau, focusing on developing a practical technical plan for recommended follow-up based on key interviews and an external technical review of the website. The audit includes an analysis of potential multimedia and social media opportunities, as well as recommendations to optimize multilingual support. Overall, there was consensus among those interviewed that the current (2010) website was not used to its full potential.

PHM strengths in relation to website development and maintenance:
- Passionate and dedicated volunteers and staff available
- Good initial use of web technologies
- Website is viewed as a key tool within a larger communication strategy
- Capable technical staff team that is well supported
- Increasing interest from members to be involved
- Diverse set of skills and experiences available in PHM
- Interest to use web technologies to support PHM as global and grassroots movement

Challenges identified with regards to website utilization, development and maintenance:
- How to increase online participation from activists in the field
- Language and distance pose challenges to collaboration
- Limited resources
- More regular updates and diverse content is needed
- Website could be more attractive and easier to find what you need

The audit suggests PHM adopt a website strategy based on the following key aims:
- Engagement and collaboration (including outreach, promoting participation and linkages)
- Resources and content (including expanded multilingual capacity)
- Presentation and visibility

3.4 Evaluation of the Right to Health Campaign

"*Right to Health Campaign Assessment*", October 2010 and "*Right to Health Campaign Phase II*", June 2011 by the Right to Health Campaign Commission

The Right to Health and Health Care Campaign evaluations are assessments by PHM of the first campaign phase ("assessment phase") in order to consider how best to move to the next campaign phase: mobilization. The first evaluation included self-assessment surveys by participating country circles followed by interviews. The

report provides an overview of the levels of implementation of the Right to Health and Health Care Campaign in the participating countries, as well as feedback on the provided support such as the campaign's assessment guide and small grants. The large list of health right themes used in national/local campaigns demonstrates how one global campaign can be relevant and made specific to local circumstances. The second report presents lessons learned from the first phase of the campaign:

- **Small grants:** requires assessment and administration which the PHM secretariat is not equipped for. The Campaign often stops when the funds are no longer available. This is the case for new circles more than older established circles. The process was frequently perceived as top down, as the grant was provided to implement a prescribed process.

- **Assessment tool**: It was recommended that the tool be made more practical and allow for adaptation to specific contexts Many groups experienced difficulty moving from the assessment to campaign activities and organizing. The process of conducting the assessment did not readily flow into organizing for the next step of the campaign.

- **National action plan:** the assessment tool and small grants system initially recommended a national approach which is not always practical, The campaign adapted to this in 2008 and agreed that local plans of action were acceptable for circles to pursue.

- **Movement building and mobilisation**: The campaign contributes to movement building by giving young circles direction and a format to organize in. Only a few of the campaigns have resulted in continued, substantial mobilisation around the RTH.

- One significant theme that emerged in feedback from the evaluation was that many countries **requested more structure for campaign activities** around which they could initiate organizing.

- During the evaluation, a disconnect and lack of **communication** between various campaigns & countries, as well as from the global level was expressed. There was a desire expressed to have more communication and idea sharing between the circles facilitated by the Global Secretariat or someone with the means to do so.

It is however concluded that the RTH Campaign has been successful in providing a way for existing PHM circles to stay involved and for new organisations to join the movement. To different degrees in different countries, it has resulted in community voices being heard, understanding of the right to health increased, and relationships built with relevant government officials.

CHAPTER 4: GLOBAL GOVERNANCE AND COMMUNICATION

PHM identifies itself as an inclusive, non-hierarchical movement. Diverse local, national, regional as well as thematic based initiatives or organizations and people can join and be a part of the PHM simply by endorsing the People's Charter for Health[9]. The following chapter highlights the main changes in the organisational structure over time and reflects on the current strengths and weaknesses experienced by those involved in the movement.

4.1 Strategic objectives

PHM documentation in its initial years shows a regular concern over the lack of strategic thinking and planning of PHM in order to maintain, expand, and strengthen the movement. Many activities were ad hoc and last minute, lacking proper discussion in relation to relevance and objectives and lacking documentation. This has improved over the years as PHM has become more structured and decision making has become more transparent and better documented.

PHM's current strategic planning document[10], covering 2010 – 2012, is the result of an extensive consultation process involving not only the Steering Council but also country circles, according to the document itself. It provides guidance in terms of PHM's current priorities and its focus is threefold: building the movement at country and grassroots level; working towards democratic global health decision making; and strengthening and democratizing the internal governance of PHM.

The following are the overarching strategic objectives for 2010 – 2012:

1. **To assist mobilization processes across the globe** around:
   a. the revitalization of comprehensive Primary Health Care as articulated in the Alma Ata Declaration as essential tool to achieve 'Health for All';
   b. the adoption of the 'Social Determinants of Health' approach to address the structural causes of ill-health.

3. **To create channels through which people's voices, especially those of the most marginalized, can be heard** and can influence the social, economic and health policies that shape their lives and livelihood and health.

4. **To enhance people's access to knowledge** through generating and disseminating reliable information about political, economic and social determinants of health.

5. **To assist, in the most participatory manner, in the formulation of evidence-based alternative policies** to achieve health for all.

6. **To assist building the capacities of civil society organizations** across the different regions in the world to be able to play their role as actors for change.

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[9] The People's Charter for Health can be endorsed through filling in the 'Charter Endorsement Form' electronically on the PHM website or posting it to the PHM Global Secretariat.

[10] *"Building the People's Health Movement on the Country and Grassroots Level Towards Democratic Global Health Decision. Plans and Activities of People's Health Movement 2010-2012" (p14).*

7. **To enhance the networking and communication among different civil society actors** across the regions and between them and other stakeholders.

The renewal of the movement's leadership, good internal governance and efficiency are added as the ultimate organizational goals.

Different PHM documents and web pages offer slightly different PHM objectives, sometimes with a different perspective (aiming to incorporate more strongly PHM at all levels instead of focusing more on PHM global) and with more or less detail but the overall picture stays the same.

4.2 PHM Structure over time

PHM emerged from the People's Health Assembly in Savar, Bangladesh in 2000 but it took several years for the movement to establish a more or less clear structure and coordination process. The following section highlights the main PHM organizational structures as agreed and/or implemented at global level.

People's Health Assemblies

People's Health Assemblies (PHAs) have been the main gathering for PHM bringing together activists, people's organizations, academics and researchers, social movements and networks, health professionals, and others together to share their successes and lessons in their struggle for health for all. The Assembly's outcome is a statement developed and endorsed by the participants that further shapes PHM's focus and intervention strategies. Each Assembly is preceded by a long-term mobilization and consultation process to shape the program, nominate representative participants from different countries and backgrounds, and contribute to the draft of the desired statement. Both Assemblies to date[11] succeed in bringing together around 1400 participants from around 80 countries the world over. A third PHA is planned to take place in South Africa in 2012.

Circles

In October 2001, the first international meeting took place to discuss the shape of the movement, the result of which was then opened up for wider consultation and feedback. This initial structure for PHM focused on two types of relatively autonomous and interlinking circles to form a "people's web": **geographical circles** (national, regional, and international); and **working circles** (combining people and organisations in areas of work for PHM). Working circles were subdivided into working circles focusing on the development and strengthening of the PHM, and those focusing on policy and lobbying work. These later became known as Thematic or Issue Based Circles. One elected representative from each of the Regional PHM Circles would be a representative in the International PHM Circle which would function as the reference body for the Global Secretariat.

Global Steering Council

PHM has a global Steering Council (SC), previously known as the Global Steering Group, that is responsible for informing the main direction and areas of focus for PHM globally. It has traditionally included representatives from the eight founding networks and organizations, regional focal points, and the current and previous

[11] PHA I took place in December 2000 in Savar, Bangladesh and PHA II took place in December 2005 in Cuenca, Ecuador.

coordinator of PHM. The SC has majority membership from low and middle-income countries.

Issues identified in documented discussions in 2005 around the functioning of the Global Steering Group include the lack of representativeness of many of the regional focal points (they were not actually (s)elected by anyone in their region necessarily and often did not communicate back to PHM affiliates and circles in their region), and lack of responsiveness of many of the Steering Group members. Notable exceptions were Latin America, North America and Australia where regional focal points had stronger communication with their regional PHM circles. Suggestions discussed included to ensure a rotation of leadership through introducing a limit of two years per function in the Steering Council or other coordination / decision making bodies at regional or global levels. The question was also raised whether the eight founding networks should still be included by default.

From within the Steering Council, a Coordinating Committee – previously known as Coordinator Commission and better known as the CoCo – is selected which meets more regularly and is responsible for the more day-to-day support to the Global Secretariat and tasks delegated by the Steering Council. They have monthly Skype meetings and they try to meet twice a year face-to-face, if funds allow.

Global Secretariat

The PHM Secretariat was initially the continued PHA I Secretariat, coordinated by Dr. Qasem Chowdhury and hosted by Gonoshasthaya Kendra (GK) in Savar, Bangalore. It has since rotated every three years to different countries and host organisations. In 2003 the Secretariat moved to Bangalore, India, where it was hosted by Community Health Cell (CHC) on behalf of *Jan Swasthya Abhiyan* (PHM India) with Dr. Ravi Narayan as the Global Coordinator. In 2005, Hani Serag took over as Global Coordinator and the Association for Health and Environmental Development (AHED) hosted the secretariat for the next three years.

Since 2009, the Secretariat of PHM has been hosted in three sites: Cairo (the previous Global Secretariat), Cape Town (the new Global Secretariat housing the Global Coordinator, Bridget Lloyd), and Delhi. Reasons for this 'separation' of the Secretariat are to save costs (Cape Town is more expensive), retain skills built during the previous years, and to expand support to the movement to deal with the increased scope of work. A division of labor has been developed and agreed to by all parties and there is regular communication and coordination between the secretariats (Appendix 12). The Steering Council meeting in August 2010 concluded that "functions [are] separated, not duplicated".

At the time of the evaluation the Cape Town Secretariat has no office. The three staff members work from their respective homes and communications happens mainly over Skype and email. The Cape Town Secretariat opted for this way of working to save money but the staff hope to be able to work from an office (part- or full time) closer to the PHA3. Apart from lack of access to office equipment like a printer and scanner, this arrangement has worked well and staff maintain regular communication as required. Communications with the other two Secretariats, in Delhi and Cairo, takes place over Skype, as do the CoCo meetings and other meetings about specific programmes (like IPHU, RTHC, WHO Watch, etc). Staff work flexi time as meetings

with global colleagues and partners frequently take place after hours due to different time zones.

PHM Global is not a registered organisation and therefore depends on a partner organization in a country be their 'host'. This has often posed challenges to the host organization as they are officially (and financially) responsible for the Global Secretariat. PHM Global often deals with more budget than the host organization itself. This requires very clear Memorandum of Understandings (MOUs), financial controls, and guidelines. There has been some research into the pro's and cons of incorporating PHM Global so as not to depend on host organisations.

4.3 Analysis of PHM structures and (needed) structural changes

"There is a strong tension between supporting the creation of the democratic spaces where ideas and actions can emerge from the struggles that people are facing… and the need to have some coordinated approaches where unified global action can be stimulated to advocate for change." -Evaluation 2004, p.28

The need for having a global governance structure of PHM is not being questioned by respondents. There are however concerns about how functional the current structure is and the (lack of) communication flows in the movement. The potential role of the regions is regularly highlighted but the current Regional Coordinators play a limited role in linking the global and national levels with each other.

Representation and responsiveness in PHM's global governance
There is awareness within the current Steering Council (including the CoCo) that it does not function optimally. It has been discussed for years already that the SC should move to more formal representation, but not much change can be seen 'on the ground' yet.

The current SC has agreed in 2010 to include representatives from the following groups in future SCs in order to increase its representativeness:

1) 10 representatives from 'well-developed' country circles (pool representation per region);
2) 4 representatives from affiliated networks (pool representation);
3) 1 representative each for the major global projects (currently IPHU, Global Health Watch (GHW), RTH Campaign but this would change over time);
4) 2-3 representatives from active thematic circles (which ones can change over time); and the
5) Current and immediate past Global Coordinators.

There will be a limit of two consecutive terms of three years for membership of the Steering Council. The Steering Council will select members of the CoCo from within its own membership, in addition to the current and immediate past Global Coordinators. The Steering Council and CoCo can invite one or two "permanent and special invitees" to one or more of their meetings, if they consider it useful for the informed decision making process. An Advisory Group is to be established by the new Steering Council. The aim is for the 'old' PHM governance structure and the 'new' to meet at PHA3.

In a document from December 2010, Steering Council members are already presented (or 'grouped') according to this new system, although no actual change has taken place yet within the SC membership. New structures take time to implement, especially as the new structure involves election processes in countries, but this waiting and lack of clarity among some SC members has led to frustration. The proposed changes was sent out the SC for comments, and later it was agreed and minuted at a SC meeting that the new structure would be implemented by PHA3, Even so some SC members remain unaware of when and if changes are going to take place at all.

> *There are changes in the way it's structured, but very few changes in the people. [There are] many documents about how to create a better governance structure, but they don't get implemented.* (SC member)

Interviews and SC and CoCo minutes reveal that there have been tensions between the Steering Council and CoCo, especially in relation to lack of responsiveness and communication in relation to decisions and decision making processes. It is felt by many PHM members, both within the SC and outside the SC, that the process of decision making is exclusive in the PHM, with just a few select individuals playing a role at the country as well as global levels. Although there may be a need for urgent and immediate decisions by a smaller group, this should be the exception rather than the norm.

> *If decisions come from CoCo, that means only three or four heads are deciding…The structure needs to be clearer, and criteria more explicit.* (SC member)
>
> *Decisions should be more accessible, and more people making them*. (PHM Latin America).
>
> *There is a real problem of communication [in the Steering Council].* (SC member)
>
> *I periodically when I'm travelling get into my PHM mailbox, so it's partly my fault. But I have no idea what's going on, no idea what's happening... Almost nothing of substance gets discussed on the Gmail Google network.* (SC member)
>
> *Some people are not stepping down even though they are never at a meeting.* (SC member)

PHM members around the globe who are not and have never been part of the SC are generally unaware of the structure and role of the SC. They have no idea how decisions are made at the global level. To enhance openness and facilitate this understanding, several SC members suggest providing more information about SC and CoCo discussions and decision on the PHM website. This would require some work to make the information more accessible, as even some experienced SC members find Steering Council communication "not easy to digest". Condensed minutes of the SC meeting in Sri Lanka (2010) were developed for broader dissemination, but it is not clear to whom they were disseminated and how they were received.

Even though I´m involved in IPHU… I´m not well informed. I don´t know what is said in the SC meeting. It´s a bit odd… In other organizations there is better internal communication, even if you are not in the inner circle. Much better if decision making were more transparent and shared with all. That would build an organization for the future…You cannot grow in the organization. (Europe)

What happens globally is not known. For example, the choice of people for any global PHM initiative is not known." (Sri Lanka)

Information on minutes remains in the Steering Committee, but we need to make this more transparent and disseminate it more widely… We really need to make very concise minutes of what happens at SC meetings to be able to share it. The fact of the matter is, like many organisations, many decisions happen outside of the SC meetings, but these need to be documented and shared. (SC member)

Representation in global governance structures of PHM are very limited when it comes to young people and grassroots activists and there is an expressed need for more regional representation. The gender balance in the governance structure will be discussed in more detail in chapter 8.

Old and Young(er) Leadership

Both members of the Steering Council and within the regions and countries express concern about the composition of the Steering Council. Over the years, governance structures of PHM have been constituted with the involvement of a small group – mostly the same group - of committed individuals. The leadership in PHM has since the beginning depended strongly on specific individuals, many of them from the eight founding networks and organisations [12], having participated in PHA-I, or having joined very soon after.

Current SC members are not limited to any duration of their term as member of the SC. This is a concern as the same people continue in positions of leadership without ensuring opportunities for new leadership to grow and be included. It is also a concern because some people are not active in their role as SC member, but there is no process to get them out of the SC.

As a movement we've struggled hard with diversity on that Council, honouring our elders. That is really valuable, but I have a sense –and I include myself as someone over 50 - that all those over 50 should be replaced by 30-40 years olds, who would be more clear about their role. (SC member)

There are just a few people within the SC who keep it going. The concern is that if some of us leave, PHM collapses. (SC member)

There seems to be a healthy amount of critique or reflection in PHM, but it could be more still. It felt like the older generation was holding on while new young folks willing to take on a lot are not given the opportunity to as they have slightly

[12] The eight founding networks and organisations are: Gonoshasthaya Kendra (GK),Health Action International – Asia Pacific (HAI-AP), Dag Hammarskjold Foundation, Asian Community Health Action Network (ACHAN), Women's Global Network for Reproductive Rights (WGNRR), International People's Health Council (IPHC), Consumers International (CI), and Third World Network (TWN).

different and sometimes broader perspectives on ways to go about advancing the agenda. (SC member)

Some SC members believe there may also be lack of clarity among some SC members over who they represent on the SC, limiting the relevance and effectiveness of their participation and contribution.

The Steering Council is not very functional, because of who's on it, and why they're on it. (SC member)

There is a suggestion from within the SC to establish an advisory body or 'Council of Elders' to appreciate and honor founding and longstanding members and ensure experiences and expertise is not lost, while allowing 'new blood' in the governance structures.

The IPHU courses are an initiative of PHM to reach out and build new leadership for the movement, but this has not actually led to any change in the global governance of PHM There is however an increasing activity of IPHU alumni in programmes like the WHO watch.

PHM Activism: Understanding and activating diverse circles

PHM's latest planning document mentions around 70 PHM country circles that the Global Secretariat is aware of, although the actual definition (size, structure, members, activeness, impact) of these country circles varies greatly. As the next chapter will demonstrate, some 'circles' are actually limited to a couple of individuals who maintain contact with the Global Coordinator, while other circles are actually existing health networks in the country, without having an 'independent' PHM presence in the country. The majority of country circles that responded to a questionnaire sent out by PHM in 2010 consider themselves networks of organizations and individuals[13]. Some circles focus around universities and academia, others are more strongly linked with broad grassroots activism, while others (mostly in the global north) are more strongly concentrated around development work and international solidarity.

Thematic circles were conceived in the PHM to track developments, generate ideas on how PHM should act, and generate positions. Respondents note that most thematic circles are not functioning[14], and some share an interest to reactive such circles. In practice, PHM seems to have largely moved away from thematic circles to 'global programmes' such as IPHU and WHO Watch (see next chapters).

Some respondents expressed concerns about the concept of establishing PHM circles, especially country circles, preferring instead to utilize existing groups and structures where possible instead of establishing new and potentially parallel or competing structures, groups or processes. This concern was expressed in several regions but most strongly in Latin America where there is generally a long history of social mobilization.

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[13] PHM Country Circles – Consolidated Report (August 2010).

14 The 2004 external evaluation of PHM already found that (thematic) circles that focus on a specific event or campaign, have a focused output, or relate directly to the ongoing work being undertaken by members tend to work more effectively.

PHM Global should respect diversity of its affiliates in the country, they may have different ways of organising or already be organised in certain ways. They may not want to call themselves "PHM" because they already have another name, but may want to be linked to PHM nonetheless. This has been a problem in some 'country circles'. (Philippines)

Another issue faced by circles and PHM partners is the lack of clarity of when and how an activity or campaign becomes a 'PHM' activity or campaign. Who can make that decision, and at which level of PHM does that decision need to be made? PHM members and partners may feel a specific event or campaign falls within the mandate of PHM (local, national, regional or global), and therefore expect PHMs contribution and participation to show support.

Grassroots representation

At the global level, many articulate and well known academics in international health are part of PHM. Their contribution to PHMs agenda and the visibility of the movement is generally well recognised and appreciated. However, they are also perceived to dominate PHMs agenda and discourse, clouding the struggles of activists at grassroots levels.

It's lovely to have discussions but academia is not going to change the world, unless it's really linked to practice. (SC member)

The PHM agenda does not reflect the priorities from Bangladesh nor from Cuenca. Because the declarations reflect the FIGHT for the right to health, and the main action of PHM is on the impact of international public health policies. (Latin America)

PHM´s agenda is focused on the governance of PHM itself and on activities to increase impact on a high level, like the forum in Geneva. (Latin America)

The People's Health Assemblies are considered an important strategy to hear the voices of grassroots and allow their struggles to lead PHM's priorities. The second People's Health Assembly in Cuenca in 2005, significantly brought the struggles and realities of indigenous peoples to the fore, with the aim to put indigenous people's rights squarely on the agenda of the right to health movement. Some concern is expressed that this has not resulted in sufficient follow-up from PHM.

The lack of inclusion of grassroots is perceived by some respondents as inherent – grassroots activists are rarely part of a global event or initiative. There is a need to be conscious of the disjunction at least and to move beyond intention, through establishment of processes and strategies to make PHM more inclusive.

Regional representation

PHM has attempted to strengthen its regionalization - as opposed to having a focus merely at global and in various countries at national or local levels – through the establishment of Regional Circles with Regional Focal Persons. As the next chapter highlights, regional coordination and action on the ground remain absent or limited in most regions. Many Regional Focal Persons are not taking action (in that capacity)

because they lack time or clarity and because they are not getting the support they may need. Many Country Circles are not aware of any Regional Focal Persons or Regional Circle. There is no mechanism yet established to (s)elect Regional Focal Persons although the new governance structure underway is based on pooling regions and election of representatives.

> *There would have to be 10 or 15 active people that say yes, X or Y represents our region or our country. That would enhance recognition of their legitimacy as representing PHM.* (North America)

In 2009, PHM expanded its secretariat to three locations in three different countries covering three regions. With the move of the PHM Global Secretariat to Cape Town in 2009, a part time position was added to support PHM movement building in Africa, specifically through outreach and networking including following up with participants of IPHU courses, the Right to Health Campaign, and supporting the development of country circles. This is very positively assessed by PHM Global Secretariat and PHM Africa members.

PHM Latin America currently functions quite autonomously from PHM global. Although language and cultural barriers are acknowledged, there is a common perception in Latin America that their expressions of activism are not much appreciated at the global level.

> *There are people who are afraid of our militancy or past militancy.* (Latin America)

Although they do not house a Global Secretariat and do not receive funding for staff positions from PHM global, a Regional Coordinator is in place for PHM Latin America to support the movement in the region, supported through funds raised by the region.

In 2010, plans were discussed in the Steering Council to support further regionalization through adding part time funded staff hosted by a PHM affiliated organization to support outreach and regional coordination of PHM activities and movement building. Outreach coordinators in Latin America, South and/or South East Asia and the Middle East have been budgeted for but lack of cash flow has forced the postponement of implementation.

Respondents from most regions report that regional representation is not currently functioning and there is a lack of awareness of whether there is any regional representation in the global Steering Council or not.

4.4 Finances and fundraising

PHM Global raises and administers finances for the Global Secretariat(s), annual meetings for the SC and an additional CoCo meeting, and for some of the global programmes such as the IPHU, Global Health Watch, and limited lobbying and representational opportunities. Additional PHM funds are raised at regional and country level, often through a host organisation that is a PHM member.

Finance

The financial structures that PHM deals with are relatively complex, because PHM Global is based in different parts of the world with different national policies and laws guiding financial management and payments, with bank accounts in different countries, and because it is not a registered, incorporated non-governmental organisation. It receives funds and makes payments in different currencies. In the past years, much effort has been put into streamlining and clarifying financial procedures and improving accountability. A Global Finance Committee is established and financial strategies and protocols developed and approved[15]. These documents clarify the financial responsibilities of different entities within PHM.

Memorandum of Understanding (MoU) guide the financial relationships between the PHM Global Secretariats and their host organisations which have a responsibility to approve and check expenditures against budget (PHM South Africa in the case of the Global Secretariat in Cape Town; Egyptian Foundation for Health fort All for Cairo secretariat; SAMA for the Delhi secretariat). For example, PHM South Africa monitors PHM Global transactions and financial records and procedures and advises CoCo if it has concerns that PHM Global's procedures are in conflict with South African law and practice.

PHM financial planning and expenditures are guided by an Annual Operating Budget that is developed by the Global Coordinator and two Associate Coordinators with support of the Secretariat and approved by the CoCo. The Operating Budget incorporates priorities set by the SC in the global Strategic Plan. The PHM Global Coordinator compiles monthly financial reports that show expenditures against budget and shares them quarterly with the CoCo for approval. In consultation with CoCo, PHM appoints an auditor to audit the PHM Global accounts annually and the auditor's report is presented to the relevant host organization(s) and the CoCo.

The Global Coordinator reports to donor agencies in accordance with funding agreements.

Level of core funds and fundraising

Currently, PHM globally is operating under severe financial constraints, and this does not look like it will be improving in the immediate future. Oxfam Novib who has been funding the core costs for some years, has informed PHM that they will no longer be funding health, and they will therefore no longer be funding PHM after 2011. Currently, PHM is waiting on funds from Oxfam Novib for two separate grants for 2011 (health systems and the exit grant), while all three secretariat office bank accounts and the central Singapore bank account are operating with a deficit. This has affected payment of staff salaries and other accounts due e.g. the travel agent account, payment to Zed books for GHW, etc.

Members of the CoCo report that fundraising is an ongoing challenge, and even more so recently with the financial crisis limiting budgets for development work and the shift in the Dutch government development priorities and budgets. PHA3 is postponed from 2011 to 2012 due to the financing gap. Limited funds challenge PHM (at all levels) to follow its own line instead of opting for donor priorities. Within the movement it is recognized that the lack of funding make activities and campaigns

[15] See: *Financial Management Policies and Procedures for Global Structures and Secretariat Operations* version 19 August 2010.

hard to realize. Most countries rely on their own fundraising and see the lack of funds as a major obstacle to their PHM work. Some individual and organizational PHM members give voluntary contributions to PHM (at different levels), in the form of money or other resources or by sharing costs of activities. Lack of funding to support country and regional coordinators are a challenge as people are limited in the amount of time they can volunteer.

> *[Being in the] Steering Council and CoCo for a world-wide movement, it's really hard. Even the organisations with lots of money have difficulties, and here we are all overstretched and there's no money.* (North America)

Several respondents mentioned the need to release core funding for regional coordination as a strategic move for mobilization.

> *We need to channelize funding for movement building. There is very little money and if it has to be distributed widely then the amount available to each is very little. We need to be strategic and use money for processes that lend to getting people to come together.* (Asia)

Fundraising is not only a challenge for PHM, but also for many of its member organizations and networks. This impacts the amount of support (including human resources, financial resources, meetings that can be 'piggy backed' onto, etc) they can give PHM as well.

PHM has managed to secure funds from a number of different donors over the years, including development NGOs from the Netherlands and the UK, Medico International, and WHO (for civil society work on Social Determinants to Health). The Global Secretariat has developed and maintains a database of (potential) funders. A challenge with further broadening the donor base is the increase in reporting that is required. The Global Secretariat reports that the priority on implementation of activities rather than reporting to donors might result in the secretariat ending up in cash flow problems.

In order to support fundraising, a Fundraising Advisory Group, which included people with donor agency contacts, was established in 2009 but it soon became inactive. Some individuals with relevant experience are now providing support to raise funds for PHA3. PHMs experience is that personal visits and support of in-country PHM members is important. The Global Secretariat has developed a fundraising strategy, approved by the CoCo, which is followed up on and regularly updated.

Although PHM Global cannot and does not want to be responsible for fundraising for all PHM activities – at all levels – it is important within the movement that fundraising efforts are coordinated as "it does not look good if different programme coordinators approach the same funders independently". The PHM Global Secretariat does already provide advice or support to national fund raising efforts as relevant and requested. For example, the Africa Outreach Coordinator supports country circles to develop plans and proposals as required.

There has been some disagreement within PHM about providing small grants ("seed money") to local or national PHM activities, as has been the case with the Right to

Health and Health Care Campaign[16]. New campaigns or country circles are glad to receive some financial support for covering the costs of their meetings, transportation and materials. But there are concerns that this might lead to country level PHM activists looking at PHM Global as their funder, expecting continued financial support for their activities. It is also felt that this develops a "project" mentality to the campaign, where activities stop as soon as the funding runs out. Finally, there is concern about the lack of capacity to adequately assess applications and monitor the use of funds.

4.5 Communication: Barriers and Opportunities

Communication is considered a cornerstone for movement building as activists need to be able to inform each other about developments, share research and good practices, and use materials to lobby for change with decision makers. One good example is Equipo Comunicándonos (EC) based in Cuenca, Ecuador. The EC involves a coordinator who receives a project salary, while all other members, based in a diversity of countries in the region, participate on a volunteer basis to help cover different events.

Improving communication, both internal and external, is highlighted as a priority of PHM throughout its years of existence. Many ideas and plans have been shared but implementation has not always taken place. Clear and timely communication is essential for transparency in decision making within the movement.

Within a global movement language is a barrier which is recognized. The charter has been translated to many languages, and the website is available in several languages, but regular communication remains a challenge.

> *We must do more but this is tough. We need volunteer translators and have never been able to set up a system for that. We have talked [about this] many times over. Improvements: the website is now in four languages. Unfortunately the [PHM-] Exchange is [only] in English. (SC member)*

The idea is that information is communicated from grassroots to PHM Global and vice versa through the country and regional Focal Persons, but in reality this is not happening. Communication between regions and between countries directly is also minimal, except perhaps as a result of IPHU courses. There seems to be more communication within PHM Latin America, although there are some concerns – from within the region and beyond - that it should be more inclusive. Within Africa communication takes places regularly, driven by the Africa Outreach Coordinator.

Most of the respondents are not really aware of the activities of the PHM beyond their state or country and have little understanding and knowledge of PHM at regional and global levels. If PHM members at country level have contact with PHM Global, it is through the Global Coordinator or 'personal' contacts (for example resulting from IPHU). Similarly, respondents who are active at the global level would like to know more from country and grassroots levels of PHM. Respondents both at country and at global levels express frustration with not being informed or updated about what is going on at the other level(s).

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[16] See also: "Right to Health Campaign, Phase II" by the RTH commission, June 2011.

A concern is raised that the IPHU, Right to Health Care Campaign, WHO Watch, GHW activities of the global PHM are in some sense "vertical" and disconnected.

> *PHM has many different activities but they are not harmonized. How do we put them together? It may be useful to look at lessons from other organizations. It would be also be useful to examine the impact of the activities vis-à-vis the Charter and PHM goals.* (Asia)

Contrary opinion that the activities are amply linked and that there is coherence among them was also articulated.

PHA3 is seen as an opportunity by many for linking grassroots with global level advocacy (and vice versa). It is suggested that new technologies will be an opportunity to link more people to the event.

Although most respondents agree that in-person meetings and events are essential for movement building, and many PHM members have become experts at 'piggy-backing' PHM events and meetings to other meetings, there is a clear understanding that PHM must depend and embrace alternative means of communication. The main communication media and tools, besides phone, Skype, and e-mail, that are used at the moment of the evaluation are:

Websites

PHM maintains and contributes to several websites (www.phmovement.org, www.ghwatch.org, www.iphu.org) in addition to the numerous national and regional PHM websites and pages that have been set up over the years such as PHM India (phm-india.org) and the Spanish language Pijuano Blogspot (pijuano.blogspot.com). Some PHM members have also been active in adding PHM (and related people, documents, events) to Wikipedia, making PHMs message more widely available.

The main PHM website is available in four languages: English, French, Spanish and Arabic. A decentralized website team with members based around the globe collaborates in the coordination and implementation of the various website updates, linkages, and translations.

> *"The collective responsibility on the development of the websites is considered one of the success stories of decentralizing the work load related to the global activities of the movement among the largest possible number of affiliated organizations and networks as well as individual health activists." - PHM Plans 2010 -2012*

These websites provide a wealth of information in different formats, and opportunities to sign up for updates or courses.

PHM was added in Wikipedia in 2009.

List-serves

PHM manages numerous list-serves at different levels and with different functions. There are several member-only list serves for internal communication between the

SC and CoCo members and between Country Focal Persons. The largest and most well known public list-serve is PHM-Exchange.

PHM Exchange (previously known as PHA-Exchange) was set up by Dr. Claudio Shuftan soon after PHA I and he still moderates the list-serve with technical support from the PHM Global Secretariat. PHM-Exchange is the main communication tool linking around 2500 people from around the world who are affiliated with or interested in PHM and/or the goal of health for all. Subscription to this list-serve is open to all and simple. Contributions can be sent in by anyone but need approval from the moderator before being shared on the list serve.

Many PHM members emphasize their appreciation for PHM-Exchange and the useful and relevant information and updates shared through this list-serve. Respondents mention that they forward messages to colleagues and others as relevant. Some PHM members are concerned that too many messages are being sent out through PHM Exchange, including irrelevant messages, and they are not able or willing to keep track of it anymore.

> *People's knowledge about PHM's global work and engagement with WHO, etc. is very limited and is not enough. People's knowledge and awareness needs to be increased. We got some idea of the global PHM during IPHU. Prior to that we did not know much. The PHM exchange is useful and we get some information from there. (Sri Lanka)*

For Spanish speakers, mainly from Latin America, the list-serve REDLATINOAMERICANASALUD serves a similar function as PHM-Exchange.

Additional list-serves exist, and may be established and maintained by different people, for specific groups such as for campaigns or thematic circles. IPHU list-serves are established with each IPHU training course for participants and lecturers to be able to continue sharing, discussing and liaising with each other.

While the PHM exchange provides updates and opportunities to share issues, strategies and other relevant information, the readers on the list are diverse and not necessarily in support of the Charter. For this reason, the Global Secretariat is in the process of also establishing a list serve which will join together PHM activists from around the globe, including IPHU alumni and people who sign up in support of the Charter. There are suggestions from country circles to establish regional e-lists across PHM country circles to exchange notes about activities, ideas, and campaigns.

Newsbrief

Over the years PHM has published 23 Newsbriefs, most of which are available on the PHM website and which were printed for distribution among organisations without easy internet access. In 2011, a new newsbrief was launched: PHM Global News.

The PHM Newsbrief is appreciated and recognised as an important source of information about the movement but some respondents would like to see more detailed information. Other respondents have never seen the Newsbrief.

Press releases
Press releases are developed as relevant and made available on the PHM website. In some cases, these press releases are then used to support local PHM protest or advocacy. Open letters to international agencies such as WHO in response to plans and new policies are also being circulated and put on the websites of PHM and Global Health Watch

Podcasts
PHM Latin America has most experience with multimedia posting and podcasting. It can be an effective tool to reach especially rural communities and people who may not be literate or may not have access to computers and internet.

> *"By building on the Latin American model and expertise, PHM can extend multimedia support and enable a more distributed and diverse audience to share in the experience of PHM events and resources" – People's Health Movement Website Audit Final Report (August 2010), p.20.*

Videos
Videos are increasingly available on PHM websites (in several languages) and used in IPHU courses.

Social Networks
PHM (including PHA3, IPHU, Global Health Watch) can be found on Facebook but this medium has been used only minimally so far. Many of the groups have not reached out to large numbers successfully and have been mostly dormant. There is a recent attempt from the Secretariat to use Facebook for regular PHA3 updates and discussion.

Twitter has been used for the WHO-Watch project, during the World Health Assembly and also notified on updates to the WHO-Watch website. It has only around 50 followers, and it is not yet strategically or successfully used by PHM in its outreach, advocacy and campaigning. There is definitely potential for PHM in using social networks to support linking of members, especially from younger generations, and sharing information and activities.

Opportunities and Challenges

- PHM strategic objectives are important and relevant and have the potential to reach out to still larger numbers of supporters and partners at grassroots, national and international levels. The challenge is to balance PHM's initiatives at the different levels and ensure linkages at all times between global advocacy and grassroots action.

- Over the years, PHM has started to 'professionalize': internal processes are more structured and better documented and there is a global strategic plan to guide decision making and planning. An action plan for a new governance structure has been developed and its implementation is planned for 2012. This process is important for transparency of the movement and to some extent

required by many donors. Finding the right balance between being too structured ('NGO-ized') and too flexible is a challenge and may be something not all supporters can agree on.

- Funding for international movements and the development sector is very limited. It seems organizations need to spend increasing amounts of time researching funding opportunities, liaising with donors, writing proposals and – when successful – reporting to donors. This affects PHM fundraising directly but also the fundraising of PHM members and supporters who face challenges within their own organization or network which may affect their participation (with financial, human, and other resources) in PHM.

- As the movement grows as is involved in more initiatives and new people join, it becomes increasingly important to improve communications within PHM as it cannot rely on personal relationships and communication between individuals as it did in many ways in the beginning. It is important to critically reflect on who may want or need access to what information, how, and when. Different audiences may require different information and/or through different channels.

CHAPTER 5: A GLOBAL MOVEMENT

This chapter will give a selective account of the expressions of PHM around the globe. It is not a comprehensive account but focuses on the more active regions of Asia, Latin America and Africa with summaries of PHM work in other parts of the world. We have chosen to give more detailed case studies of countries with different experiences and history of PHM; Ecuador, Thailand, Sri Lanka and India in appendices 8-11. A summary of the electronic survey to focal points and country representatives can be found in appendix 6. Case studies and survey findings complement each other aiming to explore challenges and opportunities for PHM from a country and regional perspective.

5.1 A movement or network?

People have different ways of thinking about what is PHM and this generates some conflicting ideas about priorities, activities and governance. The evaluation team therefore attempted to achieve a common understanding of terminology with regard to common concepts used in the PHM such as "movement", and "network". Interviews with PHM members from the global Steering Council but also 'on the ground' (active in country circles or campaigns at national or local levels) demonstrate that varying opinions exist within PHM of the significance of being a movement or a network.

> *We ourselves are a Network. We have never been incorporated as an NGO. We also want to be a Movement: moved by a Charter and open to anybody, no formal membership. If you agree with the Charter, you show your support on our homepage. We are democratic, and we work in circles, not chapters. We reach out and proselytize. We accept individuals and we do have formal NGOs with a couple of bigger organizations as part of PHM as well.* (SC member)
>
> *At PHM, we expect members to take time to diffuse the principles of the Charter and get involved locally and beyond on linking the technical with a good understanding of the structural constraints under which we all work. In an activist role we openly criticize faulty policies and injustices or violations of rights. We engage in empowering communities to claim their rights. We deal with duty bearers to engage them in a dialogue on equal terms. We participate in the political discourse of the country encouraging women and minorities to do the same.* (SC member)
>
> *There's a lack of clarity about whether we are a grassroots movement with numbers of individual activists, or a coalition. Each have very different ways of looking at representation. Whether we're some kind of network of grassroots coalitions and mainly a network. It's that very muddled nature of what we are that makes discussions very challenging, both in terms of inclusion and representation. (SC member)*

The form and identity of PHM can differ depending on the geographic area that is explored as it is influenced by local/national/regional processes; national PHMs can consider themselves a network of individuals or organizations while perceiving the global PHM to be more of a movement. While a number of respondents considered

PHM to be a loose network of organizations, others perceived it is a network of networks, while another view is to see PHM as an organization to run the movement.

> *The PHM is a movement as well as a network. As a network it has a structure, a letterhead, etcetera. I always think of it as an organization to run the movement.* (Srilanka)

> *PHM is not a movement. It has a different nature – it is a network of networks but has the involvement of social movements. We are a civil society group with a combination of people from different backgrounds.* (India)

On the other hand,

> *I think PHM is a movement because it is driven by common people, community, through action based on the decision of the people. While we, the organizations and networks, continue to advocate it is still the movement of the people. The PHM is an implementer of change and should be a movement and not an institution.* (Philippines)

> *As a network we need flat decision making structures. If the network is global then this is all the more necessary. For a movement to be taken forward, we need a decision making structure that could be contradictory to the very understanding of movement, such as the issue of proportional representation.* (India)

In Latin America, the PHM (known as Movimiento para la Salud de los Pueblos Latinoamérica –MSPLA) draws on long trajectories of organisation and political mobilising around health in the region. 'Pueblos' are Peoples, not People's. Reference to 'peoples' illustrates a significant conceptual shift from the previous all-embracing concept of 'popular', highlighting the diversity of collective actors and identities in Latin America, especially indigenous peoples, and evoking ideas of autonomy, territories and sovereignty.

> *As the movement does not have a definite physical structure it's more difficult to create a group identity. It's not like an organization that has its logo and name, but rather a movement around principles. And although there are advantages, as it can have ample outreach, but people don't find concrete things to do. I agree with the principles, but there is a lack of group identity, of doing more concrete activities.* (Brazil)

It was also opined that although the ultimate goal is that of a people's health movement, the PHM is currently a network that is expected to build or strengthen the movement. In India, the nomenclature differs at the national and state levels – "Jan Swasthya Abhiyan" translates into English as the "People's Health Campaign" while "Jana Arogya Andolana" in the state of Karnataka, translates as "People's Health Movement".

> *PHM is a misnomer. It is not a PHM but aspires to become a PHM. But this is not yet the reality and hence we must not fool ourselves.* (India)

The drawbacks of the movement structures is also highlighted by several people involved in PHM: "People do ask at meetings how you join PHM, which is not actually clear". Some PHM Steering Council members, as well as others, find the question "What do I do as PHM member" difficult to respond to. How can PHM effectively incorporate new members?

> *In some countries country circles can support and take in new activists, like in India, which is run by strong and leading NGOs and where health activism is well-established. But in other locations this is not the case, like in South Africa where civil society is mostly inactive.* (SC member)

5.2 Expressions of PHM globally

5.2.1 PHM in Latin America

Regional movement characteristics, history and context [17].
PHM in Latin America comprises a loose, informal, dynamic and incisive coming together of social movements, public health defense coalitions, grassroots umbrella organisations, intellectuals, academics, and social activists. Identification with PHM core values and vision[18] plays a crucial role in PHM's movement building in Latin America (and globally).

> *The movement is new, but primary health care is not new, and the actors aren't new.... What interests us is the essence of having a movement.* (Hugo Icú from ASECSA, Guatemala, April 2010)

"Ideas fuerza" (translated as 'key ideas') are considered the central force that brings people and movements together in PHM in Latin America. These include the right to health, primary healthcare, the critique of free trade agreements and neoliberal privatisation of health, and crucially around health and environment. IPHU constitutes an essential way for PHM to increase outreach and form new members. However, if not offered specific things to do and ways of participating, this identification remains mainly passive. Coordination successfully takes place around specific issues and in international forums, such as the World and regional Social Forums, but greater "*articulation requires more joint activities and projects"* at regional and global levels.

The region faces many similar problems: increasing concentration of wealth and growing poverty, inequality and exclusion; the reduction and privatisation of health and other public services, neoliberal models of health based on infrastructure and pharmaceutical company interests. Alarming trends exist of widespread organised crime, drugs and human trafficking, particularly of women and girls, feminicide[19], and 'social-cleansing' of youth gangs. There is an increasing sense of hopelessness among young people given scarcity of employment, many taking refuge in drugs. Social activists are increasingly being accused of terrorism and protest criminalised,

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[17] This section draws on a MSP-LA evaluation for Third World Relief (Belgium) carried out by Morna Macleod (July 2010).
[18] While evidently movements cannot be effective on identification alone, the importance of identification is a crucial component of PHM which can allow it to become an enormous world movement because of its widespread appeal and resonance. This is very different from other movements which come together to liaise, or whose core values resonate more locally or around specific identities.
[19] *Feminicide* describes the murders of the women and girls using exceptional brutality, misogyny, as well as the wide impunity related to them (lack of investigations and bringing those guilty to justice).

including people linked to the PHM. Natural disasters are on the increase, due to climate change and ecological devastation. Given this bleak panorama, members of PHM in countries like Ecuador, Argentina and Nicaragua are placing increasing emphasis on the need to work with children, and to promote '*alegría*' –joy or happiness, coined as '*alegremia*'- amongst young and old, through art, theatre and music, as well as traditional forms of indigenous spirituality and healing.

In various parts of Latin America, there is a search for 'new paradigms', recuperating indigenous knowledge, practices and epistemologies, and fundamentally questioning the western and liberal paradigm of man dominating nature. In its stead, people are exploring new socio and bio-centric paradigms which foment a more harmonious, less predatory relation between human beings and nature. Strategic social organising is centering on the defense of water and natural resources, protesting against the devastating effects of open pit mining which is damaging to the life of the environment, communities and local social-fabric. Latin American social movements, including the PHM, are spear-heading growing organisation and protest around crucial global issues affecting the world as a whole. Latin America's dynamic trajectory of social activism and movement building is an as yet potential asset which could arguably contribute to strengthening PHM vibrancy more globally.

PHM movement building in Latin America is neither lineal nor progressive. Rather, it depends on local conditions, social movement dynamics in each country, and the opportunity of strengthening PHM in specific circumstances. For example, the movement began to grow in Ecuador in 1998 in preparation for the first PHA, consolidating during the year of preparatory work for the second PHA in Cuenca in 2005. This resulted in a national coalition being formed: the National Front for Peoples' Health, which played a key role in getting the declarations' vision and agenda into the 2008 Constitution.

Another peak is currently taking place with MSP-LA co-organising the Continental Meeting around Water and the Pachamama (mother earth) at the end of June 2011 in Cuenca. PHM members occupy the uppermost echelons of the current FMLN government's Ministry of Health in El Salvador. These have carried out ample citizen participation consultations on health issues, with advisory and back-up support from key figures such as Maria Hamlin Zúniga in Nicaragua, Arturo Quizhpe and Jaime Breilh in Ecuador. In Argentina, after a dispersed and fragmentary PHM in a large country, this has now coalesced into a PHM chapter with clear activities, after people gathered around LAICRIMPO's[20] 20th anniversary at the end of 2010.

Like all international movements PHM in Latin America has ups and downs, lulls and moments of intense activity. While many identify themselves with PHM through the Savar and Cuenca PHM Declarations, the Movement thrives and blossoms on particular initiatives and activities.

It is often very difficult to separate where a national movement ends and where PHM begins. People often wear multiple hats, and collaboration takes place with the like-

[20] LAICRIMPO is a grassroots health movement which was started 20 years ago by nuns working in the North of Argentina. There are now LAICRIMPOs in Paraguay and Uruguay, and together with other members of the MSP-LA, LAICRIMPO holds annual meetings to discuss issues and exchange experiences, particularly around the 'health of the ecosystems', new paradigms of health and relations to nature.

minded. When asked if their organisation forms part of PHM, one answer from Ecuador demonstrates ambiguity: "*I'm not sure either. We collaborate with Arturo Quizhpe in the events he convenes*". The same person considered himself to be an 'occasional collaborator' for MSP-LA a year ago, and was a key organiser of PHA II in Cuenca.

While identification with specific people and positions continues locally, this points to a growing unease that their voices and priorities may not resonate with PHM globally. In various interviews, movement leadership in Latin America expressed frustration that their views, priorities and strategies feature low on PHM's global agenda. This is a situation that calls for concern, though many younger PHM activists in Latin America who engage locally, regionally and in international PHM activities do not share this concern.

Coordination

In most of Latin America, PHM has tapped into existing organisations, movements and activities, rather than creating specific PHM chapters, though each country decides how best to organise. Previous coordination nurturing the movement is the International People's Health Council (IPHC) which first brought together various key people from the Americas. In Central America, MSP-LA's backbone is the Regional Committee for Community Health Promotion, a 40 year old coalition which gave birth to and still brings together health promoter organisations in Guatemala (ASECSA 1978), Nicaragua (CISAS), Chiapas, Mexico (PRODUSSEP, subsequently EAPSEC) and the Dominican Republic (COSALUP) all founded in 1983, and later APROCSAL in El Salvador. Whereas health promoter networks were systematically decimated in the armed conflict in Colombia, in Central America they played a key role in providing health to people affected by the conflict and continue to provide vital primary healthcare in countries where state health coverage is scanty. Whereas Central America (and Chiapas, Mexico) make up a compact region with close ties and high levels of coordination (due both to size and historical ties), South America is a larger and more diverse region, with differing histories, socio-economic conditions and languages. The vast geographical, historical and cultural differences make on-the-ground coordination and networking much more difficult than in Central America.

There are PHM chapters in some parts of Latin Americas: Argentina, Colombia and Cuba. PHM Latin America works at country level and crucially as a region with Central and South American sub-regions. Decisions are taken collectively, in a loose informal fashion through consultation. Ad hoc commissions are created around specific activities –for example, the IPHU on intercultural health in Guatemala- and then disappear after the event is over. As each working group or commission works collectively and independently, decision-making is decentralised. Initiatives arise from specific countries, from the region or from PHM globally, and in principle those interested in participating take part. The risk of this more spontaneous, informal model is to ensure inclusiveness and transparency. A couple of respondents expressed feeling left out, or wanting to participate more. PHM in Latin America has been adamant about not wanting to institutionalise, as in their view, this leads to creating greater risks of power struggles and 'NGOisation' which diminishes movement qualities, potential and dynamics. In practice the movement works, as one interviewee put it, through a 'trusted circle' of people around the continent. The challenge of this model is to widen the 'trusted circle'. There is a push for holding bi

or tri-monthly meetings using new technologies, though this more systematic coordinating has not yet gelled. Various criticisms are made about the lack of planning and/or sticking to plans. Some say activities cannot be carried out for lack of funds, while others are concerned this indicates an 'NGO mentality'. Given that face-to-face coordination meetings take place while piggy-backing with other events, those who participate are those who are able to travel.

Regional and interregional connections

There are some levels of contact between the Americas, but historical, socioeconomic, cultural and language differences between Latin and North America mean that these are quite different regions. While many PHM members in the States and Canada have experience and ties with Latin America through solidarity and organisational outreach, and some Latin American activists have studied in the USA and participated in PHM there, these relations continue to be personal and isolated, and have yet to translate into greater transcontinental links within PHM.

There is potential for more significant linkages, for example around health and environment, on issues of undocumented migrants' health rights, and Free Trade Agreements. Work on health and mining could link Canada, with its companies' huge stakes in mining, with Latin America and globally. Getting to know successful community health experiences in Latin America could help organisations and activists in the US to shift from seeing their role as always offering solidarity, to being the recipients of solidarity from the global south. Then too, advocacy in Canada and the US around mining and pharmaceutical companies, government foreign policies on health and the export of US and Canadian health models through the World Bank all relate to possible collaboration within PHM as a global movement. Therefore a significant evaluation finding is the need to establish concrete activities that bring together different countries and regions around particular issues. Thus, bottom-up shared priorities and joint strategies would naturally bring different strands of PHM together, strengthening the global movement as a whole.

Tensions have been identified amongst a substantive section of PHM in Latin America with PHM globally, though this is not the case with many of the younger and newer activists. Grievances have been expressed about Latin American trajectories, viewpoints and priorities not being valued or included in the global PHM agenda. This represents a significant risk in terms of the movement's 'unity in its diversity', and the marginalisation of voices and viewpoints. A risk also exists in Latin America, where people tend to work together with the like-minded, reducing the potential for growth and diversity. Many had hoped that the PHA 2 would promote in-depth debate and solutions to these issues, and feel that PHM could become more inclusive of its diversity: "*in terms of the movement as long as we agree on the basic points, that's enough, not everyone has to agree on everything".* In this sense, rather than discussing whether PHM is grassroots-based or comprised of committed academics and NGO-coalitions, it should be all, with each having equal voice, access to decision-making and defining priorities.

At the same time, Steering Council members from Latin America do not always make use of the opportunity of being in the Steering Council to participate, contribute to discussions and decisions, and share experiences from Latin America.

Communication
In Latin America, communication takes place mainly through email, list-serves, El Pijuano blogspot, discussions by Skype and occasional face-to-face meetings, 'piggy-backing' with other events and meetings. Reports in Spanish are shared through list-serve REDLATINOAMERICANASALUD and IPHU lists. Room for improvement includes joint-planning, coordinating, and more reporting back on participation in specific events. Several interviews pointed to the need for greater information from countries other than Ecuador, and the risk of Pijuano acquiring an anti-government stance rather than reflecting the plurality of views within PHM in the region. Interviews pointed to a significant lack of communication between PHM globally and PHM in the United States (US), Canada and Latin America. Most communication and liaising are done through individuals working on specific issues.

Funding
Most of PHM's funds in Latin America come from a project funded by Third World Relief (TWR) - the development branch of INTAL - and the Belgian government. This covers the salaries of one outreach person for the region (based in Nicaragua), the person in charge of the communications' team *Equipo Comunicándonos* in Cuenca and some administrative support. Medico International (Germany) and PAHO have funded one-off small grants for specific activities (IPHU, publications and fares for international events). TWR's funding has provided the basic bread and butter funds for the movement to operate in Latin America and to produce many audio-visual and written materials. There are no funds yet to cover a face-to-face meeting, as recommended in the 2010 PHM-LA evaluation, to define the movement's platform and plan in the region, as well as ways to improve internal functioning and coordination. Most PHM activities are done through people using other institutional resources, giving their time, piggy-backing with other events, and using ways of bringing PHM into academic events (for example at the University of Cuenca), as well as through local and regional yearly events (such as the annual ASECSA meeting in Guatemala and Laicrimpo in Argentina).

Grievance was repeatedly voiced in the region about PHM-LA not receiving any funding from PHM global (except for small amounts for specific activities like plane fares for advocacy work in Geneva and funding for IPHUs), while financial support is provided for the PHM Global Secretariats in South Africa, Egypt and India. This might reflect a misunderstanding about what other regions get, as no regions receive regional/local support from PHM global different from PHM-LA. However it also stands for a feeling of being "left out" as a region in the allocation of global secretariats.

While there are clear advantages to a lack of dependency on aid agency funds, there are also substantial drawbacks: few people are prepared (or can afford) to give their time, things take much longer reducing efficiency and effectiveness. Some initiatives get dropped, and there are insufficient resources and time to give good follow-up and guidance to, for example, IPHU activists. Whereas professionals and people in better-off countries like Argentina have more time and capacity to give their time voluntarily, in poorer countries people are hard pressed with day to day survival. While this has not stopped many from participating in social mobilisation, it does have a negative toll on more systematic and structured forms of participation. Funding has become a critical issue in Latin America, as aid agencies are increasingly reducing or

retiring from the region altogether, given that many Latin American countries are 'middle income' and figure quite high on UNDP Indexes on Human Development. However, figures are often quite misleading, as income distribution is so skewed in many Latin American countries: Countries like Brazil, Mexico[21] and Guatemala figure amongst the greatest divides between the haves and have-nots in the world. Young women PHM activists in Brazil feel the only way forward is for their work to be included in PHM funding projects more globally as Brazil is not a priority and receives very little support from aid agencies.

Inclusion of women and marginalised groups

Despite entrenched machismo in the region and ongoing practices which subordinate women, binding them to the home as mothers, wives, carers, cooks and cleaners, women have taken huge strides forward in Latin America, particularly through organising and access to education. Women comprise the majority of health workers to participate in social mobilising around health, though men continue to dominate leadership and decision-making. However, in PHM in the Americas there are many strong women leaders who participate nationally and globally. Indeed, in North America the movement is mainly comprised of women activists. In the IPHU courses, there are often more women participants than men.

An important part of PHM in Latin America is working with, or indeed indirectly comprises indigenous peoples. Efforts are also being made to bring on board issues and people of diverse identities. For example, in the IPHU on Intercultural Health in Guatemala in April 2010, priority was given in the selection process to gender, ethnic, race, age and sexual preference considerations. While there has clearly been greater inclusion of indigenous peoples, their demands and worldviews, efforts are being made by some to question entrenched discrimination, particularly around LGBT and people living with HIV/AIDS. Women –particularly indigenous women- and children figure highly in Equipo Comunicándonos documentaries and videos; this is quite unusual in videos made by Latin American social movements, with the exception of women's movements.

Strategies, activities and achievements, PHM Latin America

- Strategies include: advocacy, information sharing and analysis, urgent actions, mobilising and protest, lobbying, creating proposals, community training; events bringing together communities, activists and academics; research and dissemination of findings.
- Communication strategies: networking through list-serves, Website and publications. Equipo Comunicándonos produces outstandingly high quality videos, audios and photographs.
- Health and environment: cutting-edge national and international events around water, open-pit mining, antibiotic resistance, fumigations, etc. with accompanying videos and publications
- Participatory research on social determinants of health.
- IPHU in Cuenca, Porto Alegre, Havana and Chimaltenango (4/17 IPHU so far). There are new activists resulting from IPHU (though many more do not become active). Some go on to facilitate other IPHU courses; others are involved in Global Health Watch, RTH campaign and WHO Watch. There is some follow-up and need for more.

[21] Thus several of the richest men in the world are Mexican, yet people –particularly indigenous- live in abject material poverty, with high rates of maternal, prenatal and neonatal mortality, and death from malnutrition and curable diseases in states like Chiapas, Guerrero and Oaxaca.

- In El Salvador, the National Health Forum, organised by the Ministry of Health and coordinated by Margarita Posada (the latter, the minister and vice-minister all active members of PHM), brought together 3,000 people nationally to analyse the findings of a bottom-up participatory diagnostic study with community leaders, health works and other local actors in 125 meetings to discuss sexual and reproductive health, gender based violence, disaster prevention and mitigation, access to medicines, water and environmental sanitation. Through PHM contacts the experience was then shared in Colombia, where a similar initiative has been undertaken.
- Direct input into issues to be raised through the Salvadorian Health Ministry at WHA.
- In various Latin American countries, people linked to PHM are exploring ways to bring about profound transformation in health paradigms, incorporating human rights, political economy and recuperating indigenous knowledge and health practices. This wider vision of health transcends health systems and access to medication, to conceptions of health and nature, intercultural health and notions of 'buen vivir' quality of life, and reaching out to factories, mines, the environment's health and rights (now enshrined in Ecuador's 2008 Constitution).
- Special emphasis and work with children (Ecuador, Argentina and Nicaragua) (see first section) '*alegremia*' or promoting joy, in areas affected by poverty, conflict (suicide-rates have greatly increased) and *mega* projects.
- Right to health campaigns; health promoters, midwives, primary health care
- Preparing and organising PHA II in Ecuador enhanced national coordination and the formation of the National Front for Peoples' Health and subsequent successful advocacy to include health demands and visions in the 2008 Constitution.
- Innovative approaches to health include: self-managed holistic bio-centric health practices in Rosario, Argentina, Paraguay and Uruguay; environmental clinics in Ecuador in communities affected by socio-environmental conflicts: participatory research, healthcare and human rights

Opportunities and challenges for PHM Latin America

- Key people in PHM-LA are highly proficient in new technologies and aware of their potential for increasing communication, furthering movement, and fomenting new ways of coordinating and decision-making reducing carbon footprints. This is an opportunity both for increased communication and coordination in Latin America, and with the wider PHM global movement.

- PHM in Latin America is visionary in linking health with the environment, particularly around water, dams and mining issues (also genetically modified organisms, toxic waste and fumigations, etc.). There is great potential to tap into these issues which resonate with a variety of stakeholders who could be drawn into the movement, particular young people, communities affected by dams and mines, indigenous peoples (as many water and mining concessions are in indigenous territory), environmental activists and coalitions, researchers, advocates and church groups. PHM is also in a privileged position to foster cross-country and regional initiatives, for example, bringing together PHM activists in Canada, Latin America, Asia and Africa around mining issues. Interviews in the Americas suggested great interest in working on this issue.

- PHM in Latin America still has important challenges identified in the 2010 evaluation in terms of defining a platform/plan for the region, strengthening internal functioning, communication and increasing outreach. While steps have been made, a face-to-face meeting for in-depth discussion and concrete action plans has not taken place due to lack of funds.

- PHM core values and vision resonate with an extremely wide and diverse public across the globe. There is a great potential for PHM to grow in its demands and diversity. Concretely, this means that taking on board perspectives and potential contributions from Latin America which could widen and enrich PHM. At the same time, PHM in Latin America could in itself widen and enrich, by increasing outreach to more organisations, movements, coalitions, activists and intellectuals who share PHM core values though may have a different take on health priorities and strategies in the region. Due to the nature of its core values, PHM has the potential to become an inclusive mass global movement which accommodates and expresses diversity (in terms of identities, socio-political vision, priorities, strategies and targets).

- Given their technical capacity and high-quality products, PHM in Latin America through Equipo Comunicándonos has great potential for increasing outreach through Internet television and community radios, and to further PHM visibility and positioning. EC has still to draw up its communications plan.

5.2.2 PHM in Asia[22]

In Asia, the history of the evolution of the PHM follows closely after the People's Health Assembly (PHA) at Savar, Dhaka in Bangladesh in December 2000. The PHM in India, Sri Lanka and the Philippines was inspired by and evolved from the PHA. PHM reached Thailand mostly after participation of several Thai delegates in the second People's Health Assembly.

In preparation for PHA, significant mobilization took place in India, Sri Lanka and Philippines. At the time there was no vision for a longer term and sustained PHM. In India, 18 organizations and networks were involved in the development of booklets on health issues and concerns which highlighted a collective perspective and joint positions on these issues. In India and Sri Lanka, the organizations who were involved in the process from the region were from across the political spectrum: people's movements on diverse issues, women's groups, health networks, organizations (in Sri Lanka for example) who were involved in peace building in the situation of war and conflict in the country[23], regional and global networks (Health Action International – Asia Pacific (HAI-AP), International People's Health Council (IPHC) , and even liberal religious networks. In the case of Sri Lanka representatives from the government also engaged on health issues in this process. Their motivation was possibly the outrageous status of health of the people, the belief in the non-attainment of the goal of Health for All by 2000 and the need for collective action towards attaining it. The coming together was also based on the realization that the larger global – political –scenario, such as WTO's role, impacted everyone, regardless of what sector, work, or campaigns the various organizations and networks were involved in.

In India and Sri Lanka, the process of mobilizing and deliberating about a national level movement began between 2001 and 2002. While the coming together of organizations, networks and movements under the umbrella of PHM was an emerging entity, many of the organizations were part of people's movements and country level networks, Asian regional networks, and other relevant organisations.

Role and Relevance

The importance of a sustained entity such as the PHM and the need to be part of it has been largely motivated by the need for strengthened and collective action. Organizations increasingly realized that wider mobilization on issues and of organizations and networks is necessary to strengthen campaigns and action for any significant impact at the national as well as regional levels. On their own the impact will be limited and not so wide reaching. PHM is expected to facilitate the creation and strengthening of linkages between diverse issues and identities in the context of health between organizations, movements and networks engaging with them. The role of the PHM is to forge links and to strengthen policies. This collective nature of the PHM driven by common principles has created a perception of support, strength and solidarity.

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[22] The following section draws on interviews with people in India, the Philippines, Sri Lanka, and Thailand as well as the results from the returned surveys in the region.

[23] The number of PHM organisations in Sri Lanka working on peace building is slowly growing. However, PHM Sri Lanka as an entity has not been involved very actively in this context. Some felt that it was not possible to do so at the time of the war / conflict. Even today access to areas affected by the war, ie the North Eastern region continues to be inaccessible to most.

> *PHM gives strength – it is a source of strength. At the national level, PHM provides updates and information about health that is otherwise difficult for us to access; ideas and statistics are also accessible and we discuss any problems or issues that different organizations have and resolve them accordingly.* (Sri Lanka)

Where PHM is active, it facilitates information exchange and sharing of strategies, especially with organizations which have minimal access to them.

The PHM has a major role to play in engaging with international health and development agencies towards influencing global policy on health, drugs, trade and others that promotes the right to health of the people across the countries of the globe, is pro-people, inclusive, and much more. PHM links local and national realities with international processes and facilitates a collective people's voice on global governance of health, which would otherwise be divided across groups.

The PHM country circles in India and Sri Lanka are well recognized and have had a positive impact on health policies, legislations, and programmes. In Thailand, there are links between PHM global and the National Health Commission Office and several additional individuals, but there is no clear PHM identity among people or organizations in Thailand (see annex 11 for more details).

Philippines has a local name for the PHM which people identify with. They may not recognize "PHM" but the PHM is extremely active and has been able to mobilize action and support at the grassroots particularly and has been, active at diverse levels – from the government, to university students, NGOs, etc.

Structure and functioning

The structures and functioning of the PHM country circles even within a region are varied.

PHM Sri Lanka is a growing PHM circle that currently comprises 53 organizations and decentralized initiatives have been started in three districts. Its governance structure comprises a Convener and a Coordinator, with both posts currently filled by people whom have played the role from the inception of the PHM in the country. While some PHM members prefer the status quo for reasons of convenience, lack of resources - time, financial and human - and unwillingness to take on the responsibility of coordination and leadership, others feel that the PHM governance should be based on the principles of rotation and representation.

> *This situation raises complex issues. Invariably, in a context where there are no external financial, human resources, the larger organizations with better infrastructure and support are bound to be in a better position to provide space, time, infrastructure, etc. While the taking on of responsibility by organizations is highly appreciated, it does not lead to processes of inclusion, rotational leadership, etc.* (Sri Lanka)

PHM India has a decentralized structure in which different states initiate their own campaigns and activities. The National Convenors and Joint Convenors are at the national level.

At the state level there is a state level coordinator. Some states have a core group that coordinates and is actively involved in decision making. The state of Karnataka in India, for example, is trying to work with state level decentralized bodies / processes that are representative of different regions in the state to facilitate focused work based on local priorities. While some states are very active and involved in multiple activities, others are more reactive or inactive. The JSA, the Indian chapter of the PHM, is seen as inactive in the recent past and the urgent need for its reactivation and identification and prioritization of issues and campaigns was raised repeatedly. Most respondents felt that the leadership (convenor and joint convenors) as well as the national secretariat had become inactive in the recent years. The National Health Assembly of the Indian PHM in 2007 was perceived by some as a critical milestone, which had created significant opportunities for expansion and consolidation of JSA. However, it was felt that JSA was unable to substantially consolidate. Communication was at its weakest. This was expressed about the national PHM processes and in several states. A few state processes continued to be active. Recommendations included change in leadership (convenor), the need for change in leadership and a rotational process to be implemented. An evaluation process had been discussed and was to have been implemented during the past six months. This was yet to be initiated and many respondents expressed its non implementation also as a reflection of inactive JSA and leadership. Most decisions are currently taken by the smaller group of Joint Conveners. State PHM chapters have their own and diverse structures.

Most people especially at the state level are not aware of the global Secretariat based in India and are unaware about the role it plays. Others, i.e. a majority of joint convenors and others who have a better understanding of the PHM global structures, are aware of the global secretariat in India but see it as playing a specific role.

With regard to the global secretariat that was located in India earlier, a number of respondents were aware of it but felt that there really was not much meeting ground between the global and national processes. They were perceived almost as parallel set ups. In India, the national secretariat has been funded in the past, the current one too attempted to raise funds but has not been successful. Thus the national secretariat is not against mobilizing financial support for specific aspects of its functioning.

In Sri Lanka, the PHMSL has been functioning at the national level and only recently decentralized processes were started in three districts. The decentralization has been welcomed by the PHMSL as it has enabled strengthening of local – district level mobilization, planning for more effective functioning and prioritization of health issues. PHMSL plans to have such decentralized processes in all its 9 provinces.

Regional level coordination

Although there is an appointed Regional Focal Point for PHM in Asia, there currently is no PHM-ASIA. Currently, no regional communication or coordination is taking place in Asia. The exception is the International People's Health University (IPHU) which has brought together a number of young people from the region and has been perceived as a significant contribution to the process of mobilization[24].

[24] See chapter 7 for more information on IPHU.

There are country level PHMs but they have no structure or coordination at the regional level. Most of the respondents feel that there is much to be learned and to be exchanged in regional processes, given common issues and concerns as well as to share and disseminate information and mobilize solidarity and support from each other. There is a regional presence of WHO and other UN bodies, South Asian Association for Regional Cooperation (SAARC), and bilateral trade agreements that should be "watched" and engaged with more effectively.

> *At the regional level – Asian – it is very important to have coordinated processes. Regional processes bring together and address regional concerns – many of which have common threads. (India)*

> *Some of us have had opportunities as individuals to travel and visit other countries and PHMs. Our concerns are similar and we can create solidarity around these issues. Concerns are interrelated and it would be good to understand what the impact of the WTO for example has had in other countries in the region. (Philippines)*

> *There should be regional processes that are collective - bringing the organizations and people from Asia together. We are in one region – there are regional commonalities. It is very easy to go forward and improve ourselves as one, to progress together. Our health work is similar – health systems – including the indigenous ones are alike. We have been dependent on India for medicines. Rumors have been spread by the drug mafia that medicines are "not good". Therefore regional solidarity is important.* (Sri Lanka)

Some respondents however question the relevance of a regional PHM, highlighting that regional intergovernmental platforms like ASEAN provide very limited opportunities for civil society lobby and it is more effective to target them using national (and global) level advocacy. Asia is a very large and very diverse region with generally a different language – and often more languages – per country which complicate collaboration across borders. There is also a concern that the establishment of a PHM-Asia structure would increase the distance between country level PHMs and global level PHM, in practice forming a bottle neck to effective communication and action. Notwithstanding these concerns, there is overall agreement that there is very limited communication between circles in the region even though it could be useful in terms of sharing successful strategies and solidarity.

There is general consensus that Country Circles should be involved in a process to select a regional coordinator and informed of any regional structure or activity.

PHM profile in the Asian region

Many respondents are concerned with the 'profile' of the PHM as they feel it continues to be largely middle class, 'mainstream'. While this is not negative per se and the middle class should also be part of PHM, there is need to expand and diversify and ensure wider and more inclusive participation. Although most organizations and networks that are part of PHM are rooted in the community (in India and Sri Lanka), their visibility is limited and can be strengthened. There is need to mobilize intensively at the grassroots levels and to ensure grassroots participation in all levels of PHM in national, regional and global governance structures.

Systems should be put in place to ensure transparency at country and regional levels. Mobilization has to move beyond acquaintances to include organizations; it must be broad based and include different ideological, political issues. Mobilization should also move beyond organizations and networks and include people, include communities. If it is truly a *people's* health movement.

Relevance

There seems to be consensus among respondents that PHM is "more important and relevant than ever before". It has been able to play an important role thus far in some processes and in some locations, and should play a larger role still.

> *Globalization of solidarity from below is important given the larger politics of health. (India)*

PHM provides the space in countries and globally to raise issues and concerns collectively as well as facilitates exchange of ideas, strategies and developing leadership around health issues.

The People's Charter for Health is perceived as the primary tool for mobilization and creating an identity with the PHM. In Sri Lanka, for example, the Charter was translated into Sinhala and circulated for endorsement. All those who endorse the charter are considered part of PHM.

> *However, many people don't even remember the contents of the Charter and the Charter that was presented at PHA I did not wholly emerge from a collective process of discussion. It is therefore important to undertake processes that could build on the charter now, based on the current geopolitical and social situation. If we expect the charter to form the basis of the PHM, if these are guiding principle and informs our work, we should have collective debates to compile the contents of the charter. (India)*

Mobilization around health issues is perceived as one of PHM's biggest strength by other networks, according to some respondents.

Communication

Communication is a critical component of sustaining and strengthening networks and movements. Currently, most communication is through emails, websites, and during PHM meetings. Across the board, PHM members consider the levels of communication inadequate, at all levels (local, national, regional, and global). The exception seems to be the global e-group PHM exchange, which is judged as very useful by the relatively few people who have regular access to it. In Thailand, which does not have local or national PHM meetings, the PHM exchange serves as the main line of PHM communication and information and it is regularly forwarded to relevant contacts in the country by those enlisted on the e-group.

Communication is expected at the country level to plug the gaps in information on issues, debates, campaigns, updates on policy and legislations; share and discuss strategies for action; and facilitate collective decision making. Given that PHM is a people's movement, respondents expect PHM to reach out to grassroots

organizations that may not have any or limited access to computers and internet. While lack of access to technology and lack of skills are identified as challenges in India, respondents also highlight that improved coordination could greatly improve communication. The coordinator would have to be more proactive in communicating with PHM activists, not limited to emails but ensuring communication that reaches out to diverse groups – through telephone, letters. It was felt that if the leadership was active then communication would also be effective.

Some respondents feel that "virtual communication is not always the answer, physical meetings are as important". In Sri Lanka, decentralized functioning and district level processes have facilitated the involvement of smaller and more local organizations who are not necessarily familiar with internet and/or may not have access to it. Recognizing the limitations of email, PHM Sri Lanka organizes meetings on a monthly basis. Email communication does take place but is usually initiated by a single person, the convenor.

Communication of analysis and ideological perspectives are also communicated through publications such as a newsletters in Sri Lanka and booklets in India. These materials are disseminated at different fora, thus used for outreach and broader awareness raising.

The multitude of languages and dialects between and within countries (like in India) in Asia pose an additional challenge to communication. There is no common language in Asia and although English is an official language in many countries in South Asia (but not so in most of the rest of Asia), the majority of the people do not learn to speak and understand it.

Funding

Funding in the context of PHM throws up several complexities vis-à-vis its identity, principles of inclusion, and equitable participation. While voluntarism and the non-funded nature of the PHM is highly regarded, and there is a consciousness of not institutionalizing the PHM, the need for some resources for specific aspects is articulated as necessary.

None of the Asian PHM circles addressed in this section (India, Sri Lanka, Philippines) currently receive any funding for PHM. Sri Lanka has never taken any funds from donors and depends solely on voluntary commitments and contributions from (member) organizations. PHM Philippines has also never received funds directly for PHM but always tries to piggy-back on activities funded through other sources in which PHM activists are involved. In India, the PHM National Secretariat is not funded currently, but an earlier PHM Secretariat did receive external financial support Donor funds have been mobilized for specific events, and piggy-backing on available resources of member organizations is common. At the state level, while most PHMs don't receive funding, some have raised their own funds in the past to carry out specific research on health care services. Some coordinating organizations of PHM India at state level also incorporate limited resources into their core budget that is committed to PHM through human resources and infrastructure.

According to the PHM Philippines, individual organisations who are part of the PHM receive funding but no funding is sought for the PHM to retain the spirit of the movement.

> *We don't receive any funds as PHM. Lead organizations on a particular issue get funds and then they are supported by grassroots efforts and respective organizations' help. Individual organizations usually piggy back on funded activities. For example we had some trainings – money for it, which was also attended by many of the PHM members. Therefore we had a meeting of PHM.* (Philippines)

The National secretariat in India has received funding in the past for specific activities. The present one also attempted to mobilize funds but has not been successful yet in this regard.

The lack of funds affects participation and assuming responsibilities and leadership more for some individuals and organizations than others. Especially smaller, community or people's organizations with limited infrastructure may require some financial support in order to be able to take on added responsibilities or activities. Many current PHM members expressed that they could not afford to commit too much time and sometimes were not able to participate in PHM meetings due to lack of resources.

> *If this is the people's movement and if tomorrow we want the people – such as the plantation workers to participate in the PHM, how can that be achieved? They cannot afford to travel or to miss their work. (*Sri Lanka*)*
>
> *Most organizations in PHM have no funding resources but would like to be involved in activities. We have money so we pay for the travel cost of some of our members. It is better without paying for travel and food but we need to consider that if very poor people are mobilized then how are we going to manage? (*Sri Lanka*)*
>
> *I feel funding creates a lot of problems. This way it is voluntary and stronger. For some activities and events we can get money, which will be useful. But I think it is better not to have funds for daily activities. (*Sri Lanka*)*

In Sri Lanka an overwhelming number of respondents felt that the non funded nature of the PHMSL currently is something that they relate to and believe in. They felt that funding for PHM may erode the character of the movement that PHM is or aspires to be. On the other hand, some respondents who also supported this opinion were concerned with the challenge of expanding the PHM and ensuring the poorest and marginalized become part of PHM in the absence of any funds specifically for the PHM and increasingly depleting resources of organisations.

Inclusion of issues, analysis specific to women and marginalized groups

The understanding and analysis of health issues should include various axes of marginalization. Issues that are specific to women and marginalized groups must be made explicit and the differential and disproportionate impact that global and local policies and structures may have on their health. PHM's analysis and

recommendations, including films, newsletters, charters, memorandums, and others must reflect this.

> *There may be inclusion of gender or a gendered understanding of issues but this needs to be strengthened. For example, on the issue of drugs, gendered concerns need to be highlighted. It needs to be part of our decision making process.* (India)

> *Sex workers and other such communities - no one listens to them but when we hear from groups who work with them, we realize that there is so much stigma. Not enough is being done by PHM, for example for sex workers. PHM needs to provide support to the campaign for access to ARVs [antiretroviral drugs], and must start some initiatives against marginalization – mobilizing for social change. Organizations are doing their programmes. If PHM takes it on we will have more strength as a national organization.* (Sri Lanka)

> *Gender is very much part of our campaign. There are also many men who don't understand women's issues. Among organizations here, understanding gender is part of the internal process. Even colleagues are not gender sensitive. Even within the PHM, there is a claim that there are no biases. But manifestations of the biases are not overcome. Gender misunderstanding continues. There are challenges even in the [global] Steering Council. (Philippines)*

> *With regard to marginalized and gender issues, PHM's intervention are not enough. Many more organizations working on these issues need to be identified. The understanding of the situation faced by women is quite strong but initiatives to address it are less. (Sri Lanka)*

Inclusion of women and marginalized groups in organizational structures

PHM members in Asia consider PHM governance structures not sufficiently inclusive, within country circles as well at the global level. Representation of women as well as marginalized communities as well as opportunities and spaces for them to be part of the leadership is perceived as largely inadequate. While PHM is perceived as being based on the principles of inclusion, the lack of conscious and proactive steps to strengthen processes to facilitate inclusive governance structures and implementation are a concern.

> *When we work in the field, women are the highest number who are affected. But when it comes to decision making only a few women are allowed to decide. Ordinary people who can be part of the decision making need to be mobilized.* (Sri Lanka)

Current processes of selection of representatives for a new PHM country circle are mostly based on familiarity and thus do not necessarily lend to an inclusive choice.

Achievements, PHM circles in Asia

- Recognition of PHM by State bodies and policy makers (India and Sri Lanka) and involvement of the PHM in state planning and drafting of policy, programme, legislation[1]
- Providing an 'alternative' vision to health that is people oriented (through analysis and publications)
- Influencing health policies and plans at the national level (to some extent)
- Expansion of PHM Sri Lanka
- Increased awareness within PHM on issues faced by marginalized communities such as sex workers and people living with HIV. This has supported further consensus to strengthen policy level advocacy on these issues.
- Engagement with like-minded groups (including grassroots), potential target audiences (including policy makers) and other stakeholders (including Human Rights Commissions).
- Reaching out to younger people, providing fora for discussion and analysis, building perspectives and facilitating development of future leadership through IPHU courses.

Opportunities and challenges for PHM Asia

- PHM has over the years has gained recognition nationally and internationally and is already playing a critical role in influencing and directing health policy and practice towards making them increasingly pro-people.
- Consolidation of understanding diverse issues within the PHM and through the PHM reaching out to others on these issues is a critical function. The groundwork for a "people's health movement" is already in place and when strengthened will have an extensive outreach.
- PHM comprises of a large number of persons whose knowledge and experience on diverse health issues is globally recognized. This combination provides opportunities to initiate action through different strategies.
- While the very character of PHM allows for plurality, encourages inclusion of diverse organizations and networks, they don't want to be subsumed by PHM. For networks and organizations whose focus area is not health, and who are / may want to be part of the PHM, there is an expectation that PHM will raise issues that are specific to the former's areas of work / focus. Given the wide ranging and newly emerging issues, it is a huge challenge for the PHM to create a balance / prioritize in such situations.
- Organizationally the PHM has to reflect on many issues in the region - the need for new leadership, wider mobilization and inclusion of organizations and individuals, strengthened communication, etc. Systems of rotation and representation to ensure inclusion in governance structures will also impact the future of the movement.
- The need for financial resources to enable wider mobilization, capacity building, etc. to strengthen the movement, without the PHM becoming "institutionalized" is a challenge. The PHM will have to be very conscious of it and ensure that PHM retains its "movement" character, without creating rifts within due to prioritization of issues and actions that require funding.
- At present the "Asian regional PHM" is non-functional although there is a need for regional coordination. Ways to move forward on this need to be deliberated urgently in a more collective and transparent manner and clarity on what regional coordination will entail would be useful.

5.2.3 PHM in Africa

PHM in sub-Saharan Africa begun on a small scale in Cape Town in 2008. Since then PHM has shown much progress in Africa since appointing an Africa Regional Outreach Coordinator at the PHM Global Secretariat in South Africa. She has built an active network of IPHU alumni which has served to strengthened the Movement in the region.

Contextual challenges for PHM in sub-Saharan Africa

PHM in sub- Saharan Africa operates in a wide range of contexts with different political, environmental, social and economic challenges, and varying amounts of political space. In South Africa and Ghana there is a significant degree of freedom and openness, while in Uganda[25] and Zimbabwe space for civil society to organize is severely constrained by state oppression. Paradoxically, there are also cases where the state connects with civil society when you would least expect it – for example in Zimbabwe, where a friendly Minister of Health has created space for engagement with PHM.

It is a shameful fact that, 50 years after independence swept through the continent, states are failing to address the social and economic determinants of health on the one hand, and to deliver effective health care and other services to the people on the other despite having enormous natural assets and potential sources of wealth. As Theodoulou points out in Global Dialogue, Africa is in a crisis: "Despite possessing a wealth of natural resources and a huge population, a combination potentially making for healthy economic growth, Africa is in crisis. Economically, the continent ... is crippled by debt, underdevelopment and poverty. It has the lowest standard of living in the world. Politically, it is beset by instability, corrupt and dictatorial rule, and vicious and devastating wars. These twin scourges of economic and political failure are exacerbated by a third curse that feeds off their baleful effects: an AIDS pandemic that has taken millions of African lives and wrought social havoc in several African countries. [26]

In 2002 the African Union ratified its current development plan, the New Partnership for Africa's Development (NEPAD), conceived in around 2001 by the then presidents of South Africa and Nigeria, Thabo Mbeki and Olusegun Obasango.[27] NEPAD commits member states to good governance, transparency, accountability and democracy, and grants them the right to intervene in each other's affairs in pursuit of these common goals through the African Peer Review Mechanism (APRM).[28].While NEPAD was intended to herald the 'African Rennaissance' and counter Afro-pessimism by promoting African solutions to African problems, it is soundly based on the 'Washington Consensus' and neo-liberal ideology with all its implications, as

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[25] Helen Epstein. What the US is ignoring in Uganda. *NYR Blog*, 19 July 2011. http://www.nybooks.com/blogs/nyrblog/2011/jul/19/us-support-ugandan-brutality/

[26] Paul Theodoulou. Editor's note. *GLOBAL DIALOGUE*, Volume 6 • Number 3–4 • Summer/Autumn 2004— Africa in Crisis. Available from http://www.worlddialogue.org/content.php?id=308.

[27] See: http://www.nepad.org/history

[28] For a civil society perspective on the APRM see http://www.saiia.org.za/books/implementing-the-aprm-views-from-civil-society.html

argued by Patrick Bond.[29] Bond describes the recent rise of social-movement protest in South Africa and across the continent against repression and neo-liberalism, and for "deglobalisation" and "decommodification". In South Africa partial victories have been won in relation to the provision of health services and education; limited amounts of free water and electricity; land reform; and even a "basic income grant", as advocated by churches and trade unions.

While sub-Saharan Africa has had high levels of migration throughout its history, there has been a recent increase in forced migration.[30] This is accompanied by the development of new forms of nationalism and increasing xenophobia, with episodic violence directed at 'foreigners', particularly in South Africa since the turn of the century. This has profound effects on health including the spread of communicable diseases and impacts on mental health. Women and children are the most vulnerable. On the other hand there is also a growing recognition that "healthy migration" is required to achieve development targets in the region.

Sub-Saharan Africa is the region most vulnerable to the effects of climate change, especially its sprawling cities where the effects of urbanisation aggravate extreme climatic events with direct impacts on health.[31] Indirect impacts on health include large-scale displacements and forced migration, and leading to conflict and squalid urbanisation, increasing the burden on already overburdened health systems. As climate change escalates, forced migrations due to natural and environmental disasters and conflict are certain to increase. The current drought in the Horn of Africa, the worst in 60 years has sparked a severe food crisis and high malnutrition rates.[32] While we cannot attribute an individual climatic event directly to climate change, such droughts will increase as climate change progresses, leading to recurrent or persistent human migrations.

Large-scale land acquisitions in Africa have increased in recent years, driven by the global financial crisis and concerns for food security as well as the need for biofuels in "investor" countries. In 2009 alone nearly 60 million ha– an area the size of France – was purchased or leased in comparison to an average annual expansion of global agricultural land of less than 4 million ha before 2008.[33] According to a recent briefing by GRAIN, this global land grab, if left unchecked, could spell the end of small-scale farming and rural livelihoods in numerous places around the world.[34]

Women play key roles within PHM in Africa and women's empowerment has moved to the centre of the development agenda. Yet, women remain highly vulnerable in most parts of Africa. Among the issues that face them are domestic violence, the

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[29] Bond, P. Talk left, walk right: rhetoric and reality in the New South Africa. *Global dialogue* 6 (3–4); Summer/Autumn 2004. Africa in Crisis. Available at: http://www.worlddialogue.org/content.php?id=320

[30] Forced migration refers to the movements of refugees and internally displaced people (those displaced by conflicts) as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects. See http://www.forcedmigration.org/whatisfm.htm

[31] Patz JA et al. *Nature* Vol 438|17 November 2005|doi:10.1038/nature04188

[32] *The Guardian*, 28 June 2011.http://www.guardian.co.uk/environment/2011/jun/28/africa-drought-kenya-somalia-famine

[33] The Oakland Institute. June 2011. http://media.oaklandinstitute.org/sites/oaklandinstitute.org/files/OI_FAQsjune5.pdf

[34] GRAIN, (24 October 2008). Seized: The 2008 landgrab for food and financial security. http://www.grain.org/article/entries/93-seized-the-2008-landgrab-for-food-and-financial-security

devastating effects of war and natural disasters where women and children always bear the worst burdens, marginalization from land and food insecurity, and poor education and health systems. Maternal and young child mortality remain unacceptably high in many sub-Saharan African countries, with lack of progress towards meeting the Millennium Development Goals 4 and 5.[35]

The LGBT community is regarded with hostility in many African countries and even criminal charges.

Country reports

PHM circles have formed in several countries in Sub-Saharan Africa, with networks both within countries and at regional level, as well as with a wide variety of civil society organizations and government structures and processes. While there are well-functioning links between organizations in most countries there are also fault lines and divisions that hamper cohesiveness. This is best discussed by looking at the situation of PHM in a selection of countries.

PHM in South Africa

PHM-SA is small but active. The Cape Town circle has a functional Steering Committee that meets regularly. All its members are committed volunteers and activists in diverse terrains ranging from health and human rights, community mobilisation, information technology, women's and gender issues, refugee issues, and health and development. While highly committed to PHM, they lead busy lives elsewhere and are limited in the time they can commit. There is also a PHM circle in Johannesburg.

PHM-SA ran out of funds in late 2010 and had to close its office early in 2011. However, funding has since been sourced for a joint project with the Alternative Development Information Centre (AIDC), and a new coordinator has been appointed.

The current activities extend the Right to Health Campaign focus on community mobilisation around the South African government's "10 Point Plan" to improve the country's public health service, including the establishment of a National Health Insurance. "A key challenge for PHM-SA is the sorry state of the Left in the country" – (David Sanders)

The Communist Party and the main trade union alliance (the Congress of South African Trade Unions – COSATU) are in an increasingly uncomfortable alliance with the ruling party, the African National Congress (the "Tripartite Alliance"). While there are critical and sometimes dissenting voices within all three alliance members including the ANC itself, the ANC continues to follow the anti-poor neoliberal macroeconomic policy it adopted in 1996.

This has resulted in growing inequality: the level of inequality in the country is now greater than it was under white minority rule and the apartheid policies, and South Africa remains among the most unequal countries in the world. Key leadership

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[35] Countdown to 2015 global initiative. http://www.childinfo.org/countdown.html

figures have been seduced by the trappings of extreme wealth and corruption is widespread. While there have been significant advances in some areas towards the progressive realization of social and economic rights as required by the constitution, progress has been slow and uneven, largely as a result of conservative macro-economics, widespread corruption and internal divisions inside the ruling party. The country has seen a rapid mushrooming of protest marches and demonstrations, often turning violent. These have been met with increasingly harsh and sometimes brutal oppressive measures by the state.

PHM in South Africa has good working relationships with other progressive organizations and networks across a wide political spectrum, including the Alternative Information and Development Centre (AIDC), Women on Farms, the Democratic Left Front, the National Education, Health and Allied Workers' Union (NEHAWU), and the SA Municipal Workers' Union (SAMWU), the Institute for Democracy in Africa (IDASA), student organizations, and so on.

In some cases, however, efforts to involve key like-minded organizations in joint action around the Right to Health Campaign and organizing the 3rd People's Health Assembly have had mixed results. Such organizations include Section 27 (which campaigns for realization of the social and economic rights enshrined in Section 27 of the SA Constitution), the Treatment Action Campaign (TAC) and the Social Justice Coalition (SJC). While some individual organizational members have participated in activities, organizations themselves have not come on board.

PHM in Zimbabwe

In Zimbabwe, there is fragmentation of civil society "at all levels mainly as a result of fighting for a very fast shrinking funding cake ... [this] is our greatest threat as we are now loosing focus of the real issues whilst wasting energy resource mobilisation and back biting" (Itai Rusike).

Zimbabwe PHM is part of a highly organized health civil society network under the leadership of the Community Working Group on Health (CWGH) which coordinates community structures across the country. The CWGH houses the PHM Desk. It coordinates with EQUINET at regional level, and has links into global movements like the World Social Forum. It uses a mailing list to organize and plan steering committee and other meetings. It has also started regional outreach meetings where public discussions are organized on topical issues.

PHM in Zimbabwe campaigns for the inclusion of the right to health in the new Zimbabwe constitution and for the right to health to be included in the new Public Health Act. The constitution is now at the drafting stage; this will be followed by referendum. At the regional level, PHM Zimbabwe shares these experiences in the constitution making process with Uganda and Tanzania.

PHM has a good working relationship in Zimbabwe with the Ministry of Health—the PHM Zimbabwe Steering Committee Chairperson is also the Deputy Chairperson of the Public Health Advisory Board (representing civil society), and sits on a number of national committees in the Ministry of Health. The CWGH has an MOU with the Ministry of Health and Parliament of Zimbabwe as it provides technical support to the Parliamentary Portfolio Committee on Health.

Until recently, there was no coordination of Zimbabwe's IPHU alumni, some of whom had even attended the course without the knowledge of the country circle. Largely thanks to the Regional Outreach Coordinator there now exists a data base of all the IPHU alumni; they also act as resource persons in outreach meetings. They invited PHM Regional Outreach Coordinator to attend their planning meeting in March 2011. They have also organized exchange visits with PHM Cape Town, Malawi and Zambia for them to come to Zimbabwe with the CWGH financing their trips.

PHM in Ghana

PHM-Ghana has a dedicated core group of volunteers and member organizations from diverse academic, professional, gender and geographical backgrounds. They have a strong organizational capacity and are able to enlist support directly from their own and from other partner organizations. However, like in South Africa, their PHM work sometimes puts them under enormous pressure because they have to balance it with their full time responsibilities in their jobs. Lack of funds hinders the effective coordination of activities.

Communication within the country, Africa and the global circles has been frequent, cordial and effective. Members (in particular IPHU alumni) have both individual links and official communication with PHM structures nationally, regionally, between country circles, and with PHM global secretariat and IPHU faculty.

As a result there are strong connections between PHM circles in Ghana and regional PHM structures. Their contacts with global structures are also very important. The global secretariat links them with potential access to resources and expertise that would be missing in an entirely local movement. Contact with global PHM also gives greater leverage and potential for influencing decisions locally and internationally through dialogue.

Within Ghana itself, the political environment is relatively stable, with room for civil society to contribute to policy development and decisions around health matters. PHM has strong links with the Ghana AIDS Commission, while links with the Policy Planning Monitoring and Evaluation division of the MoH (the division responsible for national health policy making) are relatively weak. However, these linkages can be strengthened, and explored as an entry point to regional and global public health decision making. This is helped by access to key officials in the MoH; and openness of WHO country officials to dialogue with civil society.

There are also wider networks, coalitions, alliances etc in areas of social justice, good governance, education, water etc all of which have influence on health and for which PHM-Ghana can join forces with.

PHM's vision of Health for All is broader and more encompassing than most of the movements in Ghana. Many networks are very specific – depending on funding streams they tend to focus narrowly on HIV, Water, Housing, etc. Thus, PHM can bring value by linking all these issues (eg by calling for action on the Social Determinants of Health).

PHM forms part of the Coalition of NGOs, a formally constituted structure with good governance and elaborate structures across the country and a great ability to

mobilize nationally. The coalition is recognized by government and "gets invited to the table". However, its policy analysis is very weak, and PHM can strengthen this aspect of its work. Furthermore, the Coalition's ability to engage with high level decision makers to link local issues with national and global processes is weak. Again this is the kind of value PHM, as part of the global movement can add. An IPHU in Ghana would bring enormous benefits to this.

While links with international civil society such as Oxfam and the Netherlands Development Organization (SNV) are still weak, these links and relationships could be improved -- including through links established through WHO watch.

At the global level, PHM-Ghana is involved in the WHO Watch initiative through the participation of John Mahama. There has been continuous sharing of experiences and inputs from members of PHM-Ghana in this initiative. Also, a number of members have expressed interest in getting involved in the wider global and regional health governance issues. PHM-Ghana is also involved in the mobilization for PHA 3 and is set to launch the GHW 3 report as soon as it comes from the print. They hope to link this launch with the annual civil society health forum in Ghana; and also use that as a mobilization platform for PHA 3.

PHM-Ghana could not participate in the PHM's Right to Health and Healthcare Campaign as the structures were not well established then. However, individual members of PHM-Ghana participate in civil society forums, TV appearances and departmental seminars that discuss the right to health. Some support to link these efforts with the global right to health campaign would have allowed the adaption and use of common tools etc which will promote the sharing of lessons across countries. PHM-Ghana is still opened to taking part in this campaign as soon as the new conceptualization is defined.

PHM in Nigeria

Nigeria has a large population, a complex political terrain and a wide land mass. The small numbers of PHM members and IPHU alumni, though committed, are scattered across the country. The political terrain is complex and there is a lack of funds to carry out any concrete activity. However, PHM Nigeria is in the process of getting registered with the Corporate Affairs Commission -- after which it will be eligible to apply for funding.

PHM Nigeria participated in the WHO watch programme, and established good international contacts in Geneva, which they are now trying to build on. They also network with other NGOs including ECDF (Educational Coordination and Development Foundation), POTHE (Popular theatre for health education), Niger Delta Human Rights. They have also made courtesy calls to Lagos State Agency for the Control of HIV/AIDS and Lagos state Ministry of health.

Other civil society organisations include Centre for Organisational Development, the Jim Paul Foundation, MSM and Gay societies, Keen and Care Initiative and Network of People Living with HIV/AIDS Civil Society for HIV/ AIDS in Nigeria.

PHM Nigeria has regular contact with John Mahama (PHM Ghana) as well as the Global Office and the Africa Regional Outreach Coordinator.

Strategies, activities and achievements, PHM Africa

- PHM now has contacts in at least 20 African countries and there is a growing number of circles in at least 14. Things are going particularly well in countries like Zimbabwe, Nigeria (which has 2 PHM circles), Kenya, Congo and Ghana.

- The International People's Health Universities (IPHU) in Kenya and Senegal have proven to be key focal points for networking and a key catalyst of movement building in Africa. Both the African IPHUs have opened up people's eyes and minds to the intricacies of the political economy of health and stimulated an interest in PHM. Activities have been planned, including setting up communication channels such as a blog [http://www.phmafrica.blogspot.com/] linked to the PHM website, PHM Africa facebook and google group, PHM country circles, and Right to Health Campaigns.

- The existence of a Regional Outreach Coordinator has proven to be successful for follow-up of IPHU alumni and movement building in the region

Opportunities and challenges for PHM Africa

- Collaborative relationships and activities with other networks and other movements are sometimes problematic. Sometimes this is because the organization may be working in politically fraught and unstable contexts where participating in PHM's activities and other human rights advocacy campaigns may be dangerous. Once off activities such as petitions or endorsements have functioned, but difficult to have a continued collaborative process.

- Communication is a big problem in Africa. Internet access is relatively low in general and very unevenly distributed. Bandwidth is often very limited. Email and social networking work well in most areas where internet access is possible, but Skype does not work well in many areas. Mobile phones are far more accessible and one of our challenges is to find ways of using them for better communication.

- To get the most out of the Outreach Coordinator's work it is essential to provide enough funding for travel. It is especially urgent to be able to have face-to-face meetings in countries that are planning activities.

- It is a struggle to find a balance between the need to respond to urgent local issues of the day (such as attending to the basic needs of vulnerable communities in event of, for example fires, floods or conflicts) against the need to pursue long-term undertakings in policy and advocacy.

5.2.4 PHM in North America

PHM in the USA and Canada are largely country-based, with minimal interaction and coordination between the two. There is a well-organised PHM in the US (mainly in the Bay Area of California, Seattle, New York and Boston) which joins together around 20-45 active members as it's PHM US Coordinating Group, "*it depends on the moment and what you're working on".* There are currently attempts to enlarge and strengthen PHM USA. This year PHM US is organising its first National strategic planning meeting with members to map out the next 2-3 years.

> *We'd like to build it much more, and we've got a meeting in July. We hope as an outcome to increase participation in PHM, and increase the number of organisations and groups involved. This will be a national meeting. We intend to vote on how we can be represented at the Steering Council, once the plans for governance transition are established.* (USA)

PHM USA has a relatively clear structure in terms of how it is organized:

> *In the US there is a Coordinating Group of 20 – 45 active members and various working groups – some ad hoc and others on-going ones. We hold Coordinating Group calls every other month, and there are also various working group calls. A Convenor is selected once a year to convene Coordinating Group meetings for a year, to put together the agenda, organise the call scheduling, and ensure that the working groups/committees send things out. The working groups/ committees include some that are ad hoc and organized about preparing activities -- for example, IPHU will be in June, and there is a working group organizing for that. Other working groups have responsibilities for on-going tasks, such as the list-serve and Website. .* (USA)

People are encouraged to present themselves with two hats at public meetings: as their local organisation and the People's Health Movement.

> *We really want to organise people in the US to work on both US issues, and to lobby the US government on international issues that affect the health of others around the world.* (USA)

Information is shared through US and Canadian PHM list-serves with their contacts.

> *We put out a little digest of what people are doing and contact lists. I generally send this out as well; we also send it to the Steering Committee. It is intended to help people know: here are the activities, and here is how you can engage. I wish this could also happen more at global level.* (USA)

In Canada, PHM is comprised mainly of a one-way list-serve, some people meeting for the first time not in Canada but at the PHA II in Cuenca in 2005. In Vancouver the Alliance of People´s Health is active, and has successfully mobilized local grassroots organizations. However there is little two-way communication within Canada and also a sense of being in isolated from PHM globally. There is potential for growth as PHM core values have great resonance and some activists are deeply involved with many community groups, social movements and coalitions, while others work in NGOs and

universities. However, work has yet been done to propitiate discussion, two-way information flows, as well as giving more shape, defining priorities and promoting active PHM participation. There is a lack of clarity on how and when one can organize something 'as PHM'.

> *At the moment, I can't go out and hold a forum in the name of PHM. I'm completely out of touch with the international CoCo and have no contact with them whatsoever. So the connections are there potentially, but what we need is more clarity about how to take things forward in concrete terms".* (Canada)

5.2.5 PHM in Europe

In Europe there is a loose network of a few PHM enthusiasts, consisting of academics and NGOs with interest in global health and international solidarity work. There have been difficulties to involve NGOs working on European issues who already feel that they have their communication and advocacy channels. PHM has a general good reputation though and PHM material is popular among many groups and institutions.

Funding for PHM activities in low and middle income countries has been provided by Third World Relief (the development branch of INTAL) and the Belgian government. Dag Hammarskjöld foundation based in Sweden was one of the founding organizations and supported the mobilization of funds during the initial years including PHA in Cuenca. The foundation has since changed focus and it now not actively involved in the PHM.
The Frankfurt based organisation "Medico International" has worked jointly with PHM. In 2009 Medico International organised for example an alternative conference as a form of protest against the World Health Summit which was criticized for being a "elitist club of decision makers" ignoring social factor of global health issues and the notion of health as a human right.

Lately there been activities around teaching in Global Health at medical schools and individuals have taken initiatives.

> *After a few years of discouragement, in the last couple of years, young medical students and doctors are taking a more active role and also networking internationally…* (Europe)

PHM. UK has also almost independently organized two IPHU courses and is currently trying to find a format for courses which will fit the national context. However there is a lack or regional coordination and communication and that is a concern among many individuals.

> *We need more communications - at least 2-3 communications per year - it would be good to revitalise the PHM Europe mailing list - it seems to be dead; WHA in Geneva in May is a good opportunity for many of us to meet and renew ideas and passions, but there is no communication on it in mailing lists of PHM thus, only those who are in direct contact know what is being planned.* (Europe)

Some feel unsure if they have the "authority" to represent PHM and do not know in what capacity they can act.

> *It is not clear to me when I can sign and present as PHM, I see others who do so, but I don´t know how it works...*(Europe)

5.2.6 Pacific/ Australia/New Zealand

The goal of the PHM in Australia, known as PHM Oz, is to (re-)establish health and equitable development as top priorities in local, national and international policy-making, with comprehensive primary health care as a central strategy to achieve these priorities. It also aims to draw on and support people's movements in their struggles to build long-term and sustainable solutions to health problems.

In Australia PHM is characterized by a loose network or interested people connected via e-mail discussion list (200-400 people) and a small group (20-40) of more committed activists based in Melbourne, Victoria which meets monthly to organize activities and campaigns and a group in Adelaide, South Australia who organise occasional meetings and campaigns to support other social movement (such as a campaign on water) . New members are also invited to these discussion meetings. In New Zealand the movement has been alive through an e-mail list with individuals and small groups engaging for events and advocacy. A national meeting is held annual coinciding with the Australian Public Health Association meeting. The e-mail list is currently dormant, and there is no active leadership for PHM in New Zealand. In Papua there is no active movement.

"The main challenges are the distance of Australia from the rest of the world and the difficulties in making links with global issues. We are currently having some success engaging people around issues of trade and health in the Pacific..." (Australia).

Within Australia a Memorandum of Understanding has been signed with the Public Health Association of Australia signifying the organization's commitment to collaborate on strategic objective relating to social justice and equity public health service.

To be more effective the focal person in Australia sees a need to "develop from a loose network into a more organised structure and make closer links with grassroot organisations"

None of PHM circles in the regions have any fundraising activities.

CHAPTER 6: A GLOBAL ACTOR FOR CHANGE

"There has never been so much value for money regarding Health for All as in the investment in PHM in the last 10 years…" - Halfdahn Mahler (18 January 2011)

During the last years PHM has had a number of global initiatives and activities, such as:

- Global Health Watch (GHW)
- Right to Health Campaign (RTH)
- Global Health Governance (including WHO Watch)
- International People's Health University (IPHU)
- Partnership with World Social Forum (WSF)
- People's Health Assembly (PHA)
- Advocacy & Networking at international meetings and conferences

Partners and donors do appreciate PHM for its strong and 'different' voice, for making ripples in the water. PHM is increasingly recognized as an important player at the global level and more and more invitations are sent to PHM to be part of larger structures. At the global level, at least in certain arenas, PHM is much appreciated and well-known. This humbles PHM members but at the same time drives them to stay active.

> *People seem to think we're bigger than we really are.* (SC member)

PHM as a Movement has been growing at country level and internationally; - both processes influence each other mutually and will require extraordinary efficiency in resource- use to meet expectations of community-based participants in the Movement. Apart from this huge challenge, one of the key questions in the global 'equity' debate remains: *"How much of global medical and health resources are being used for increasing of collective health coverage and primary care, and which proportion goes to the "enhancement" of health in the privileged few?* This question was highlighted world-wide as priority policy in health through the Primary Health Care (PHC) debate in the period in the 1970s[36] and remains since in the forefront in all development debates of global health governance.

This chapter deals with current global strategies and policies of PHM, particularly in interaction with the World Health Organisation (WHO) and is based on interviews with staff from WHO and other international agencies in Geneva as well as PHM members within the Global Health Governance programme.

6.1 PHM's Global Strategy in interaction with WHO

After a long consultation process PHM decided and confirmed in its "Plans and Activities of People´s Health movement 2010 -2012" the notion that a 'bottom-up' process from grassroots level to global initiatives is the way forward for the Movement. This global mobilization process will be motored by:

- The revitalization of PHC as essential tool and instrument for the process.
- The adoption of the 'Social determinants' of Health' approach to determine priority themes for promotion in universal health coverage

[36] World Health Organization. The Alma Ata declaration, USSR, 1978

- Creating channels through which people can influence HiAP – 'health in all policies'
- Improving knowledge about reliable information on root causes of ill-health through community-based surveillance
- Assisting with evidence-based formulation of alternative policies in interaction with WHO and other partners
- Perceiving 'civic society' organizations as major and determining actors for change
- Promote net-working in civic society and other stakeholders.

These proposals also state *"that continuous renewal of the movement's leadership and good internal governance…are considered as ultimate goals."*

6.2 Comparing WHO and PHM basic principles and modes of action

- **The platform of the WHO and PHM Mission are respectively stated in WHO's Constitution of 1948 and PHM's Charter of 2000 (later amended).**
- While WHO is a **Specialized Agency of the United Nations System** since 1948, whose members are mainly Independent States and Territories,
- PHM is a **Movement**, with presence in approximately 70 countries and supported by **Individuals and NGOs**, subscribing to PHM's Charter.
- The official membership of WHO are 193 States or Territories, who provide directive and policy guidelines to WHO's Secretariat through the annual World Health Assembly and the Executive Board (EB) with 42 Individual Members, nominated in rotation.
- WHO's **administrative regions are six**, while PHM coordinates its work currently **in 11 regions**. This difference might have a profound effect on different prioritization of policy and governance issues, since 'regionality' and its specific health priorities are reflected in alternative ways.
- PHM has the Charter agreed by a 'Constituents Peoples Health Assembly' (first in Bangladesh, December 2000), and later amended in successive Peoples' Health Assemblies which are scheduled to take place every 5 years.
- Both, WHO and PHM have Global Secretariats; WHO permanently in Geneva and PHM rotating (currently in South Africa).
- Both organizations promote "Health for All", which in current language use might translate to "Universality in Health Access".
- While WHO is primarily a '**Health Standard Setting**' and **'Health Development'** Organization (technically and politically), PHM is profiled as a world-wide **'Advocacy'** body, with emphasis on Equity, Universal Access to Health, Global Health Rights and Social Indicators for Health. 'Health as Human Right' is a major issue in PHMs activism, while Neo-liberalism, Commoditization of Health as well as Privatization of Health Care Delivery as consequence of Globalization are perceived as destructive to 'Health for All' by PHM.

Both Organisations publish a **World Health Report** (WHR) (however, in different intervals). PHM's report called "**Global Health Watch**" (GHW) has been published twice, in 2004 and 2008. While WHO's (mostly annual) WHR is focused on a very specific theme of highly perceived importance in global governance (e.g. 2010 "Health Financing"), PHM's GHW covers a wide range of politically critical topics, and

has a large number (about 150) contributors, with wide ranging expertise in different fields of public and international health. The notion of "alternative" WHR indicates already that GHW is seen as a precious campaign resource for political activists in the area of "right to health'.

There is one major difference in **WHO's and PHM's definition of Health**: WHO's definition states "**Physical, Mental and Social Health**" in its Constitution, while PHM speaks of **"Physical, Mental and Spiritual Health** in its Charter. "Spirituality" in PHM does not necessarily refer to religions, but can refer to a dimension of human experience and the relationship to land and nature. This difference of definition might however find its consequences when "Evidence Based Health Policies and Outcomes become basic principles of Health-for-All-related policy in the Promotive, Preventive and Therapeutic Domaine. While this difference make hardly a difference in health-care management by faith-based institutions, as long as they use globally agreed and rationally derived principles and protocols, it plays a major role in the perception of Global Health Governance, where faith-based Health NGOs demand an increasing role, while certain religious groups (e.g. Islamic faith-based NGOs) can be disfavoured due to the current political climate. The conflict -bound notion (Samuel Huntington) of culture needs therefore to be re-examined, in order to avoid falsely controversial exchanges in the future, although labeled as 'evidence-based'.

6.3 Perception of PHM by WHO staff: summary of findings

Most discussion partners in WHO headquarters in Geneva have a very positive image of individual PHM members, whom they have met during the World Health Assembly (WHA) and Executive Board (EB) meeting. They describe these PHM members as "highly articulate activists" with a "clear and very often highly professional individual profile".

WHO's Secretariat staff is well aware that the implementation of health programmes, legislation and directives as directed by EB and WHA, implemented by the WHO Secretariat, "needs much more human resources than available, to be updated and to be evidence-based at all times..." and therefore requires continued input from the interested 'stakeholder community' in all countries , particularly in "non-consensual" programmes (those programmes which depend mostly on extrabudgetary funding). WHO's Global Secretariat would therefore be interested to open their consultation process to International NGOs.

The fact that PHM as a pressure group is not present between sessions of EB and WHA in Geneva, since not represented in Geneva through a permanent office makes it difficult for WHO staff to develop permanent and continuous working relationships with PHM and is seen as the "single most important factor inhibiting intensifying and expanding relationships". Many other NGOs with focus on international health issues have a permanent representation in Geneva (called the "Humanitarian World Capital" by some), particularly when accredited by WHO and/or other UN agencies.

When this theme was explored further, most informants from WHO pointed to the necessity of more and repeated "evidence-based country studies" in particular in the field of Equity issues (such as women's health, poverty, access to food, generic drugs, and health financing) which are not exclusively health professional domains.

Most discussion partners would therefore welcome a continuous working relationship with PHM.

WHO head quarter staff is only all too aware, that 'resolution coalitions' in the Assembly and the EB have often roots in regional political issues, which are not necessarily contingent. For this reason they propose a strengthening of the country presence of PHM; and advocacy of the Ministry of Health and the WHO Representative.

Many partners pointed to the PHC history in the seventies, when the global effort of Alma-Ata was efficiently counter-acted not only by the effects of the International Monetary Fund´s (IMF) Structural Adjustment Policy, but also by very conscious neo-liberal efforts and Private Health Financing proponents, who "determinedly "changed the common use and meaning of the vocabulary and jargon of PHC into advocacy for "therapeutic basic health care...etc".

In conclusion, they pointed out that advocacy of specific issues must start at country level, to have impact in EB and WHA. It is clear from interviews with WHO staff that "stakeholders" are mainly EB members, and ministerial representatives at WHA. To query the 'representativeness' of WHA members opinion, will require "evidence-based" country studies, lobbying and advocacy by Civil Society long before issues are tabled in EB and WHA. The contingency inherent and basic to this perception of a system model reflects obviously most views of current trans-national organizations, where the question of hierarchy of importance of issues as well as decision making is never posed but silently assumed as "given".

6.4 PHM's current approach and intervention at WHO´s executive

In 2011, PHM for the first time organized an IPHU course just prior to the WHO EB as a way of training "WHO Watchers", who are selected young PHM members interested in the political/administrative processes of global health politics/governance. The first course in 2011 had twelve participants. This is a new strategy for PHM, allowing for more detailed discussions during and after EB sessions with the members. The priorities and content of IPHUs will be set in concordance with the priorities of the annually determined PHM agenda.
During the WHA 64 and EB 128 and 129 the 'WHO Watchers'(WWs) assisted all sessions in a pre-programmed way, covering all aspects and sessions. Detailed preparation had briefed them on political issues within the various groups of Member states. The WWs engaged delegates in formal and informal discussions on arguments detailed in a letter, addressed to all members/ delegations of WHA and EB. Daily meetings summarized observations and comments and clarified the "way the issues were moving". These summaries were published on a website available to PHM members. With the help of the WWs it was also possible to publish widely the "Delhi Statement". Through the dynamic activity during the WHA it was possible to have a daily meeting with other observer NGOs at the WHA on the topic of WHO reform, which was decided in this year's WHA. The EB following this year´s WHA decided a strict time-line and thematic restrictions for the WHO reform process, which required that 3 papers on specific WHO reform issues had to be produced by end June '11. The WWs presence and acuity was certainly a factor that under PHM leadership a platform could be created to address critically the WHO reform process in a very informed way through a letter to the International Missions accredited in

Geneva. This was important for two reasons: The reform process foresees "inclusive consultations" and the EB decided on active membership participation in the reform process.

PHM addressed a letter to the individual members of the EB, highlighting 14 programmatic issues ("Public Health, innovation and intellectual property", "Global Immunization, Vision and Strategy", "The Future of Financing WHO".... etc) of 40 agenda items, programmed for EB 128. It highlighted that "WHO does not make it easy for civil society NGO to contribute to its considerations", referring to the restricted access to the WHA, and that WHO "is more welcoming of private sector organizations than people's organizations." The letter compared it to the work of the Commission on Social Determinants which was more accessible. The letter announced that "a WHO PHM Liaison Group...follow(s)...the discussion at EB". It is not clear whether this letter had any impact, as WHO headquarter staff interviewed for this evaluation was not aware of the letter.

6.5 The Global Health Watch

The Global Health Watch, first produced in 2005 has been important in building the profile of PHM. During the WHA in 2003, a partnership of PHM, Global Equity Gauge Alliance (GEGA) and MedAct considered to produce an 'alternative' World Health Report (WHR), since WHO reports and specifically the Annual WHR did not include internal auditing of management performance of WHO as well as that the predominantly technocratic/financial/economic approach of the global institutions violated the stated goals of Alma Ata. The Global Health Watch (GHW) report project would be a widely inclusive and collaborative effort giving emphasis to

- human rights issues as basis for health policy and global health governance;
- counteract market-driven and transnational financial interest in health;
- highlight political, social and economic barriers for improved health and universal coverage; and
- to improve civil society's capacity to act for the disadvantaged and poor world-wide.

The preparation of GHW 3, planned for 2011, has found a larger coalition of partners including the Third World Network (TWN), Medico International, Cordaid, Health Action International and Italian Health Watch. This is a positive development but to involve non-English speaking regions remains a challenge.

In addition to following up on issues addressed in the first two GHW issues, the upcoming edition will include current critical thinking on:

- the development and change of the current international institutional (UN-) reforms and architecture, which have major impact on global health governance;
- developments and changes of National Health Systems including health financing with its impact on universal coverage;
- The Watching Section: critical issue analysis of global processes and institutions impacting on health.

The GHW document is seen as a tool for a strategy of changing attitudes in different target audiences. It is a lobbying tool to discuss informally with health policy makers on all levels of the global system. Within PHM as well as from outsiders including

government staff there is generally high appreciation for the GHW as a useful, well-researched, and interesting report.

Opportunities and challenges

- Lobbying Ministries of Health and WHO Country Representatives at country level and/or through regional representation.
- The current strategy to train WHO Watchers and give emphasis to the younger PHM members is a grand opportunity. The complications of the EB and WHA process are well perceived by PHM but can currently not be met due the lack of capacity (human and material) within the Movement. For this reason, priority setting of issues has highest necessity in the considerations of PHM's leadership to maximize impact on specific global issues. There is need however for a coherent and continuous evaluation and monitoring of the WHO Watch Training
- Emergency Relief Management and Humanitarian Action needs to be considered by PHM as a major global health policy issue.as access to health services in emergencies is limited and often not equitable.
- The mandate of PHM is perceived by respondents from the WHO Secretariat as very positive and potentially constructive. Most WHO staff have expressed their need for more and continuous input by PHM "as the only global network of that Stature".
- The current evaluation of PHM has led us to consider, that not only the global systems (such as "WHO" or "health governance" or "Primary Health Care") are changing at a rapidly increasing pace .More important seems the fact that increasingly impact, duration, direction and permanence of traditional "lobbying" needs to adapt to changes in perception of priority health needs (climate change, disaster impacts, ecology, and other newly emerging priority issues).
- The high mobility of the 'moving target" of the i.e. "universal access to health"(numbers of people affected as well as regions change frequently) requires increasingly an approach that rapidly and timely catches 'windows of opportunity' for action of groups such as PHM.
- While such scenario blurs to some extent classic policy goals and options, the reality of current and future health policy making on a 'global' scale will be increasingly imprecise and punctual. Metrics will determine increasingly the rightwing socio-economic mandate of optimization of 'value for money'.
- In this paradigm, there will be increasingly less space for 'absolute' value of human life. The mission recommends for this reason, a contemporary adequate approach to "anthropotechnique" in PHM - the human condition, which determines health in 2011.

CHAPTER 7: INTERNATIONAL PEOPLE´S HEALTH UNIVERSITY

The International People's Health University (IPHU) is often characterized as "the main education and research arm of the PHM globally. The overall aim of IPHU is "to contribute to 'Health for all' by strengthening people's health movements across the globe by organizing and resourcing learning, sharing and planning opportunities for people's health activists, particularly from Third World countries" [37].

Seventeen courses have been organized so far Sub-Saharan Africa, Middle East and North Africa, India, South Eastern Asia, Latin America, Europe and North America. The first course was held in Ecuador in 2005, the second in India 2007 and since then at least three courses has been organized every year. This reflects a remarkable achievement considering the low resource base available. The intense course activities have been possible thanks to the enthusiasm and commitment by a few individuals. In the forthcoming years an increase to six courses annually is anticipated, which will require a shift in the organizational structure of IPHU..

The courses have lasted between one and two weeks, some of them have been bilingual.

The role of IPHU as related to PHM is of key interest in the present evaluation, since the maintenance and recruitment of activists to the PHM are, in part, dependent on how successful the IPHU courses are in equipping participants with appropriate knowledge and skills to be advocating health for all in their own contexts. In the African region special attention has been given to the follow up of IPHU alumni through a regional outreach coordinator. In addition, IPHUs role in creating networks among activists is put forward by some of our informants as another key issue to the successful development of PHM.

A web-based questionnaire was completed by 116 students for the present evaluation; all courses had someone responding although the response rate was relatively low. In the following sections and in appendix 7 we present the main findings from the interviews and questionnaires on the IPHU along with information retrieved from sources available to us.

7.1 Course organization and faculty

IPHU has grown "organically" and has depended on local interests and funding. David Legge from Australia has been the IPHU coordinator from the start and works together with Hani Serag and Azza Sallam at the Cairo office who are responsible for administration, marketing on PHM-exchange and fundraising. Most of the already conducted courses (only excluding the ones in UK) were organized directly by David Legge and by the IPHU global organizing body jointly with local partner organization. Local resources and organisations like Medico International, Rockfeller and Oxfam Novib have funded IPHU courses. Most funds are used on sponsoring participants flights and accommodation as well as covering costs of faculty and facilitators. Accommodation is usually sourced low cost through local partners. It has not been so easy to get funding, but raising money for IPHU is reported to be easier than for other activities within PHM.

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[37] http://www.iphu.org/en accessed May, 2011.

Faculty members are appointed to fulfill a mix between high-profile academic personnel and health activists of sound experiences. It has sometimes been challenging to find appropriate local faculty. There has also been an opportunity to volunteer to participate in the teaching of IPHUs. Efforts have been made to have responsible "topic" teachers, who were also supposed to be responsible for resources on the web. It has not functioned well due to lack of time and organisation. Facilitators to discussion and group work have been recruited among local activists and IPHU alumni

The current organisation of the IPHU is centralised to a few people. How to develop the organisation is a future is a challenge. Some favour a more centralised organisation within IPHU although recognising the need to include new coordinators. Others would welcome a more decentralised organisation with closer links to the regional activities.

> *There should be a central academic commission and then regional sub-commissions to provide follow-up in each region. IPHU are meant to create a pool of new cadres, however, there are no cadres. The courses are announced through Internet, scholarships are announced, and everyone who wants applies. They return happily. But it's more of an event, not a process, and the IPHU should provide a progressive process of formation. The materials used should also be systematized.* (SC member)

7.2 Student interest, recruitment, and selection

Most courses have accommodated 30-60 participants. A total of 710 health activists from 53 countries have joined the 17 organized courses up to 2010. Depending on the setting many of the participants were given scholarships covering their travel and accommodation costs. According to many respondents, students are recruited mostly through colleagues, and the PHM exchange, mirroring that students are already activists, some also involved in PHM, before joining the courses.

Reasons for applying to the courses were to know more on health related topics, activism, global issues and learn more about PHM. The chance to get to know other activists and create networks was another incentive mentioned by many participants.

> *The idea of a global movement for health and good life, hoping to learn more about global health politics and what to do against it, how to work together globally with different topics, how to work as a movement...* (Alumni Havana Cuba 2009)

Selection of participants has been made through teams for each course together with David Legge as a link to the IPHU organizing body. The selection has usually followed these steps:

1. Assessing the applications received by 3-5 people among them is one or more representatives for the local partners. Each of the assessment team suggests a score for each application and individual scores are thoroughly discussed in case of discrepancy to reach possible farer average score);.

2. Deciding on the scholarships within the available budget for each course considering geographical balance (the representation of the largest possible number of countries within the catchment area for the course, and gender balance (at elast

40% of the course participants should be women). In addition, diversity of skills, activism and education backgrounds to be considered.

In general, participants of each course can be categorized as:

- 30% from the host country (the courses organized in Canada, USA, UK and India were exceptions as most of the participants were from the hosting country due to different financial arrangements).
- 50% from the same region (excluding the hosting country).
- 20% from the rest of the world (especially from countries that speak the same language as used in the course)[38].

Some have questioned this policy of participant selection and argue that it would be more effective to have more participants from similar locations in order to facilitate organization and follow up after the course.

The selection procedure is being revised since it is felt that has not been completely successful in including the participants who will engage in PHM work. Many expressed the need to recruit more locally based students with a history of activism the forthcoming courses.

7.3 Course content and pedagogy

When asked about the content, organization and venue of the courses the answers varied considerably. Since courses have been organized in many different places it is difficult to compare and draw conclusions. However in general participants were very positive and valued the courses as good or excellent. Most students stated that their expectations of the course were met. Residential courses were appreciated for their opportunities of interactions between students and faculty. It was seen as important that the course include a mix of lectures, group activities, site visits and common activities such as role play, drama, music etc. The mix of teaching methods was much appreciated although some voiced criticism regarding the teaching style.

> *...I would have liked to have less "teacher centred methods" and less lectures. Methods could have placed more emphasis on small groups, fieldtrips, open sharing, scenarios with stronger participation by participants.* (Alumni Savar, Bangladesh, 2007)

Some questioned to what extent cross-cutting themes like spirituality and gender were really integrated in the course.

> *The sessions on gender and spirituality were brief and less engaging; it felt like addressing women's issues was not a priority.* (Alumni, Cairo Egypt, 2008)

> *Rather than a one hour session on gender and marginalized issues, [it would be] better to integrate the training. There is some effort, but doesn´t go nearly far enough.* (Alumni, Sri Lanka, 2010)

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[38] Legge D, Serag H and Sallan A. Struggle for Health. A report on the activities of The International People´s Health University (IPHU). Submitted to the PHM Steering Council meeting (August 2010 Sri Lanka).

Structure and Program
In each of the IPHU courses, the program has been structured and planned to meet the following principles

- Covering the main adopted course topics including: the architecture of global health governance as a sub-domain of the global economic governance; health system policies; primary health care (PHC) as the best tool to achieve health for all; multi and bi-lateral trade regulations and their impact on people's health; social determinants of health including intercultural factors; research as one of the tools for health activism; and health and health care finance including the international development assistance. Responding to other major issues that shape people's health in certain realities/regions/countries. Such issues are identified for each course jointly with the local partners.
- Providing a space for 'learning from experience'. Participants are always asked to share their experience to initiate a critical discussion and analysis.
- Providing a relatively large space for collective work on future plans (through dividing the course participants into geographical and thematic-based groups).
- Making time for participants to know each other (personally and professionally) through organizing a space for culture exchange and excursion.

Source: Legge D, Serag H and Sallan A. Struggle for Health. A report on the activities of The International People´s Health University (IPHU). Submitted to the PHM Steering Council meeting

Some suggestions for the future included:

- More focus on strategies for young activists
- Specialised and advanced courses
- Make course materials available on CDs / DVDs for each course
- Better use of on-line resources.
- To have courses on regular intervals in fixed placed scheduled well in advance

Some of these suggestions is in line with current plans presented by the IPHU coordinating body in 2010 to the SC where the following directions for further development.

- Investing in increasing the IPHU 'online' capacity: as virtual university, the IPHU need much stronger capacity for utilizing the web in teaching, in making available a larger resource library, in obtaining feed backs, etc. (more resourceful and interactive IPHU website).
- Organizing advanced specialized courses for the IPHU alumni; e.g. course on Global Health Governance (as a part of the GHG reform project linked with the IPHU). (see chapter 6)

7.4 Evaluations

Evaluations are useful for discussion on how successful (or not) teaching methods, course content etc have been. Since the start of the IPHU evaluations during and after the courses have been conducted. The evaluations seem to have been most useful as a monitoring tool during an on-going course. There is lack of resources to timely analyse evaluations after the courses. There is an ambition to have long term evaluations of alumni activities but it has been hard to realise. What would signify

"success" on a long term is also not agreed upon and David Legge suggests it might be good to have a debate about which benchmark should be used to measure "post-course" activities against. There are today no set standards.

Evaluation routines for IPHU courses

1. Daily evaluation session: during the course, an organizing committee is formed from the course director, course organizers, course facilitators and representatives of the participants' groups. The committee is convened at the end of each day to thoroughly evaluate the day in terms of program (session by session), time keeping, degree of participation, any changes needed for the next day, and general recommendation for the next courses. Groups' representatives had to collect the feed-back from their groups before the evaluation session. The evaluation session was always made opened for any participants want to attend and contribute.

2. Evaluation forms: starting from Cuenca course, an evaluation form was designed, modified for each course to collect participants' opinions and recommendations in relation to the program (session by session), the faculty, the facilitation, the organization, the venue, the accommodation place, etc.

Source: Legge D, Serag H and Sallan A. Struggle for Health. A report on the activities of The International People´s Health University (IPHU). Submitted to the PHM Steering Council meeting (August 2010 Sri Lanka).

7.5 Engagement in PHM after IPHU

An important role of IPHU is to build new/younger leadership for PHM. It has succeeded in engaging activists and potential activists, raising awareness on the political economy of health, but courses have not resulted in broadening the core group as much as wished for.

Many alumni stress the need to facilitate networking and virtual platforms for alumni. Although a lot of communication is on-going and there are several web-sites to find information from as well interact with, there seem to be too great differences in the possibilities to access and part-take in these virtual activities. It requires some regular forum for IPHU students that are easy to access and to manage.

> *Currently all communication is only via mailing lists. Participants from different batches do not know each other or do not necessarily get to know each other, even if they are in the same country...There is no way for me currently to find our who are the IPHU alumni in for example Nigeria except contacting the IPHU facilitator and asking them whether they know someone who know someone and so on...* (Alumni IPHU 2007 Savar Bangladesh)

From the questionnaires we conclude that a group of participants in the IPHU courses have become more active in the PHM after the course. Many have continued to be in touch with PHM members afterwards, but most importantly, many of them report that they would like to be even more engaged. The willingness to engage is high, but many feel that they do not know how to engage. The follow up after the course is mentioned as a weak area both among alumni and PHM members

"Lots of projects and plans were developed but almost all tapered off some after the short course because the networks of students did not stay in touch, and people in the team were not followed up with or accountable to follow up with their project group. (IPHU alumni Cuenca Ecuador 2005.)

However theTeadsdale Corti[39]. project came out of an idea at the first IPHU in Cuenca. The project received funding for three years from Canada and has resulted in 23 PHC projects around the world.

The challenges of post course activities are well recognized within PHM. Providing assistance to the implementation of the thematic/geographical projects of participants is stated to be a key activity.

There are positive examples how IPHU has played a crucial role in strengthening PHM. The examples of Ghana in particular and the Africa region in general should be highlighted. The whole idea of a PHM-Ghana was mooted by IPHU alumni who realized the need for such a movement in the country. Furthermore, when IPHU alumni get connected with each other – partly by encouraging other health activists to apply for the courses – it develops a critical mass of trained members take up the challenge of mobilizing the movement locally. IPHU courses also provide great opportunities for networking across countries and building "communities of practice".

Participation by IPHU alumni in the Global health watch process gives them further direct exposure to the issues of global health decision making, and lot of mentoring and capacity development beyond the boundaries of classroom or the covers of textbooks.

The Africa Regional Outreach Coordinator, Linda Mashingaidze, has played a central and crucial role in the success of the IPHU as a mobilizing tool in Ghana. Her follow-up of the IPHU that was held in Kisumu, Kenya, last year has had an enormous impact on the development of PHM in Africa, and in keeping things moving forward -- asking for updates on progress, reminders, keeping people in contact, just generally stimulating us to do the necessary things.

"I would say that more than 90% of email in the period after Kisumu came from Linda." (IPHU alumni, Kisumu, Kenya 2010)

"I think the IPHU has a great impact in my country. PHM was almost nonexistent in Nigeria before we went to Kisumu. Another set also went to Senegal, though I honestly feel we haven't done as much as I would have loved us to do … not many committed members and also members scattered all over our large land mass. Though I am optimistic as soon as we get registered with the CAC and able to get some funding we would hold a physical meeting. I have also participated in the WHO Watch and it was a very nice for me, I learnt as many things than I learnt throughout my days in Medical School, I have shared my experience on the blog and I think it would also be published in the newsletter." (IPHU alumni, Kisumu, Kenya 2010)

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[39] For more information see, http://www.globalhealthequity.ca/projects/proj_revitalizing/index.shtml

Many state that the courses have been useful for them even though it has not led them to be directly involved in PHM. Many alumni expressed the course as an "eye-opener" which made them reflect on how to continue to learn and act according to the principles thought in the course. One informant, who is not involved in PHM, shared how he decided to take up studying for a Master degree in Public Health when he realised that his knowledge on health issues were not good enough. He concluded that *"the [IPHU] course meant a new life for me".*

Challenges and opportunities

- Course organisation well structured but depending on very few people, which makes the organisation vulnerable. An increasing demand of courses put more demand on organisers.
- Weak linkages with regional and country levels for follow up after the courses. Not enough of offering/planning for opportunities for IPHU alumni to get involved in PHM at different levels or thematically. Africa is an exception and show the importance of coordination for outreach activities.
- Limited use of on-line resources. A mix of teaching methods, better preparation and follow up could be achieved with a creative use of new communication technology.
- Specialised courses like the one for "WHO Watchers" reflect a promising development for IPHU. Curses on movement building, how to set up a country circle and fundraising would also be of interest to many.
- Alumni fantastic resource for new courses and other activities, but needs to be organised.
- To find the balance between central/regional organisations as well as structured strategy and "organic growth" will require further discussions.

CHAPTER 8: GENDER

The need for stronger gendered analysis and for a better gender balance within the PHM is repeatedly mentioned by some PHM activists. These weaknesses have been recognized at the global level already for years but finding a realistic strategy, the capacity, and the commitment to implement change remains a challenge. In order to review progress to date and provide suggestions for further action, gender was included by PHM as an essential element in this evaluation.

8.1 Gender in PHM's mission and objectives

PHM's guidance on gender essentially comes from the People's Charter for Health which acknowledges gender inequalities and recognizes the importance of supporting women's health and addressing gender gaps in access to health, labour rights[40], and protection from violence. It highlights the need to conduct gender assessments on economic policies.

What the People's Charter for Health says about women and gender:

- *The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion,* ***gender****, age, abilities, sexual orientation or class.*
- *Insist that all economic policies be subject to health, equity,* ***gender*** *and environmental impact assessments and include enforceable regulatory measures to ensure compliance.*
- *Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise … the contribution of unpaid labour, especially the unrecognised work of* ***women****.*
- ***Women*** *are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.*
- *Ensure that all* ***women*** *and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.*
- *Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly* ***girl*** *children and* ***women****, and for quality early childhood education and care.*
- *Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of* ***women****, children and minorities.*
- *Oppose sex tourism and the global traffic of* ***women*** *and children.*
- *War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially* ***women*** *and children.*
- *Condemn the use of child soldiers, and the abuse and rape, torture and killing of* ***women*** *and children.*

[source: Background Paper for People's Health Movement Steering Council discussion on Gender mainstreaming and Gender Programs, August 2010]

[40] There is some ambiguity in the Charter about the rights of (female) sex workers, as it calls on people of the world to oppose sex tourism, thereby seemingly denying sex workers their clients and livelihood. On the other hand, the rights of sex workers, including their access to health care, are explicitly supported in the Mumbai Declaration and Indian Women's Health Charter, and in the course of this evaluation PHM Sri Lanka has expressed the need for PHM to do more to ensure sex workers' voices are heard.

The Charter also speaks out in support of "the right to reproductive and sexual self-determination", mentioning access to safe and effective contraception and freedom from coercive measures to regulate fertility. Although it is not explicitly mentioned, reproductive and sexual self-determination also refers to women's right to abortion[41] and women and men's freedom to decide on their own partner, regardless of one's sexual orientation[42].

The Mumbai Declaration from 2004 goes into more detail to highlight women's right to health as well as to other specific marginalized groups including indigenous peoples, migrant workers and people with disabilities. It also addresses the issue of gender within PHM by calling on PHM and civil society to "ensure gender equity within the movement and within their own networks and communities".

The People's Charter on HIV and AIDS, developed in 2004, mentions the need to address the "special needs of women and children as infected persons, their dependents and caregivers" and suggests to "empower women and youth as key players in HIV interventions".

The Cuenca Declaration, endorsed at PHA II in 2005, criticizes patriarchal culture and acknowledges that neo-liberal policies result in increased gender inequalities. It explicitly states its support for access to safe abortion for all women and girls. It makes the link with gender inequalities within the movement through the following commitment: "men and women of PHM commit themselves to deconstruct patriarchal relations in private and public life".

In 2007, the Indian Women's Health Charter was launched. It shares a brief background and analysis followed by a list of demands covering diverse topics including sexual health, reproductive health, ethics in medical research, indigenous healing systems, violence against women, the specific needs of different age groups (girls and young women, and elderly women), women with disabilities, single women, women workers, and other specific groups of vulnerable or marginalized women.

Gender is not explicitly mentioned in the current objectives but "gender mainstreaming" and "addressing gender inequities" are mentioned as a cross-cutting strategy for PHM's work. The only elaborations on this can be found in the section on the International People's Health University (IPHU) courses which intend to address gender inequity in health work and gender balance in terms of its students, and in the section addressing PHM's Steering Council's membership. Gender mainstreaming does not seem to have been operationalized in other sections of PHM strategies and programmes.

8.2 Gender balance in global governance

In the many discussions over the past years about the global governance structure of PHM, it has been recognized that there is a need to have more women and more age diversity within the Steering Council and other governance and leadership structures

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[41] PHM has demonstrated this by, for example, supporting Space Allies in Japan for freedom of choice for abortion.

[42] "Sexual orientation" is mentioned explicitly in the Charter: "The attainment of the highest possible level of health and well-being is a fundamental human rights, regardless of a person's ... sexual orientation..." PHM has also developed petitions around homophobic and violent responses to homosexuality in Africa.

of PHM. There has regularly been discussion around gender and age quota, but no clear implementation plan or policy in this regard has been agreed to. PHM's planning document covering 2010 – 2012 highlights "mainstreaming gender and addressing gender inequities... [as] one of the major cross cutting strategies of our work". But so far, actions to tackle the lack of gender balance and ensure gender mainstreaming and gender focus in PHM analysis and programmes have been lacking or insufficient.

PHM currently has several women in leadership positions including a female Global Coordinator and a female co-chair of the Steering Council. Just about one third of the Steering Council members are women and three of the eleven members of the CoCo are women. Several leading organisations in PHM have a strong focus on gender and/or women, including the founding network Women's Global Network for Reproductive Rights (WGNRR), and a number of experienced gender and women's rights activists can be found within PHM. According to information provided by regional and country focal persons to the SC in 2010, Latin America and North America have good gender representation in their membership and governance.

However, the majority of the respondents feel that PHM's current processes and structures are not adequately inclusive and steps should be taken to address this. Especially longstanding PHM members express concern about male dominance within PHMs governance structures which has contributed to lost opportunities to get women on board. When asked about the gender relations within PHM globally, strong middle-age women with significant organising trajectories point to male privilege and power:

> *The Steering Council is mainly comprised of men - men who talk to each other. If a woman makes a comment, she's rarely credited for [it].* (SC member)

> *I believe that particularly some of the older men in PHM really do struggle with overcoming their issues on gender. And I've seen at meetings when these are chaired by them, they call on men much more than on women. They do really try, but it is a part of their make-up. I am assertive… but I have to really fight to be heard. Because we are older women with power, we're allowed to. But even so, it's a struggle.* (SC member)

Interestingly, several of the younger women interviewed who participate in global PHM activities did not have the same perception and experience.

> *We [younger, female PHM members] have always been recognised. I'm young, but I've always felt respected… We don't have that much experience, so we were surprised to be taken into account. Perhaps we have less claims and expectations.* (Latin America)

8.3 Gender in PHM analyses, campaigns and programmes

Respondents highlight that gender is not only a matter of male/female balance in the movement, but that gender inequality also needs to be addressed in PHM's analyses, campaigns and programmes. The Charter and other guiding documents for PHM provide ample opportunity for PHM to take on gender within all their research and activism.

> *There are lots of gender perspectives in health issues, and those most involved in health at lower levels are women... [but] women's interests and aspirations have not been integrated... things in PHM are generally seen from a non-gendered lens.* (Canada)

Across the regions, national and local PHM initiatives are taking place to address gender inequalities and sexual rights. Some examples:

- India developed a Women's Health Charter in 2007 and campaigns against violence against women and against coercive population policies.
- PHM in Africa is mobilizing around Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) issues.
- PHM South Africa is lobbying for improved conditions for Community Health Workers, mostly women.
- PHM Australia has addressed maternal and child health in the Pacific.
- PHM Canada actively contributes to abortion debates and concerns itself with the recognition of the role of women as primary care givers.

[source: Background paper for PHM SC discussion on Gender Mainstreaming and Gender Programmes, August 2010]

> *[There is a need to] Reflect on some of the ways that PHM functions, aspects of how the network is set up, decisions are made. A gendered perspective needs to be included in all sorts of aspects. Reproductive health is addressed by PHM - if at all) - mostly related to Maternal Health, but there is little inclusion of other reproductive health issues including sexual health and rights, coerced sterilization, abortion.* (SC member)

8.4 PHM Gender Committee

The newly formed PHM Gender Committee, initiated by the SC in August 2010, is a preliminary step towards 'gendering' the movement, intended to focus on strengthening gender equality and understanding within the movement itself as well as in the analysis and activities of PHM. However, even before the Committee has even started its work there is already concern within the SC that this Committee is not actually getting sufficient support and priority within PHM. After almost one year of being established, members of the Gender Committee concur that not much has happened yet in this group.

> *This group should raise concerns related to gender from an intersectional perspective that includes an understanding of how class, caste, race, disability and other societal positioning interlock with gender and peoples' struggles for life and health.* (SC member)

Respondents are concerned that although women's health and gender is considered very important at local or national levels, there is not much to show for it at the global level.

CHAPTER 9: CONCLUSIONS

PHM as a movement is just over ten years old now. It has grown from being a group of selected individuals coming together to organize the first People's Health Assembly in Bangladesh and consequently attempt to follow-up on this process by e-mail to reiterate the importance and urgency of the Alma Ata Declaration to an extensive network of individuals, groups, organizations, and networks across the globe who – regardless of their differences – unite in the struggle for health. This struggle can take many different forms, include different groups, and focus on different targets but they all come together in solidarity in the People's Charter for Health. PHM is a movement because people make it a movement. PHM is a network because of the relevance of linking people and peoples, of linking realities and experiences, because of the need to link struggles in order to address the root causes that negatively affect the people's and peoples' health as a result of neo-liberal globalization and bad policies.

The starting point of this evaluation has been the People's Charter for Health and subsequent people's declarations. They form the core of the People's Health Movement's mission which focuses around the concepts of 'Primary Health Care', 'Health for All', and 'Health as a Human Right'. These concepts are broad, globally accepted principles and indeed form the basis of the value system shared by people who are active in the People's Health Movement.

The evaluation team became aware of a wide range of more detailed enunciated priorities within the Movement such as 'social determinants of health', political views by PHM members, definitions of "activism" and "militancy" in the Movement, and distinct definitions of "movement" and "network" which found in turn a variety of interpretations by members of the movement of "what is the right mode of action and where are we going".

Whatever aspect of PHM is assessed, there are a few common challenges that keep appearing across the regions, programmes, circles, and national-global divides:

- Generation gap between young activists and the Primary Health Care generation;
- Inadequate representation by marginalized groups and women in the Movement;
- Lack of an effective communication strategy that ensures PHM initiatives are shared and people are linked by building bridges between language-, geographical-, thematic divides, and between local-national-regional and global levels.

This is occurring in a time of increasing complexities in global health governance with multiple new actors, acceleration of new technology and global financial crisis.

In this section we will return to the questions that the evaluation team started off with and summarize the findings of the evaluation.

1. ***Do the current strategic objectives of the 'organizational component' of the movement adequately respond to the movement's mission articulated by the People´s Charter for Health and other strategic documents?***

The current strategic objectives of PHM focus strongly on providing support to local and national groups to advocate for Primary Health Care and the adoption of the social determinants to health approach, as the basis of the People's Charter for Health. This is envisioned through: providing opportunities for grass roots voices to be heard; generating and sharing knowledge, developing alternative policies that support health for all; building capacity of civil society organizations; and through promoting networking and communication. Gender is added as a 'cross-cutting strategy' though there is not much more elaboration on what that means.

PHM has over the past years increased its reach and visibility and has become a unifying movement for many networks, organisations and individuals concerned with the 'Right to Health' and 'Health as a Human Right'. PHM actively promotes the Alma Ata Declaration that calls for 'Health for All' and keeps it 'alive' with activists, health workers, development workers, academics, and policy makers around the globe. Not only has PHM kept Alma Ata 'alive', it has also contributed to its implementation and to the renewal of the thinking around 'Health for All' including the relevance of social determinants to health.

The People's Charter for Health, in addition to the additional People's Declarations that have followed, are very encompassing documents that call on health to be seen in its interconnectedness with all other sectors and as a result of global processes that are taking place around us. It sets out an alternative set of values to the neo-liberal view of the world and calls on action on many fronts. As such it carries a strong symbolic value. Overall, members of PHM all seem strongly connected to the analysis and messages of the People's Charter for Health. Some people in PHM would like to see PHM taking on more or different issues than it has been so far, ensuring the broadness of the vision is fully captured in the priorities of PHM. In this regard, there is a lack of strategy and clarity on how to bring diverse topics under the PHM umbrella. Some aspects of the Charter are seen to be too low on the priorities list of PHM Global for too long, such as women's health and sexual and reproductive health rights. Another issue that has been raised in different regions as an area of interest for more action is climate change as well as mining and its consequences for people's livelihoods and well being in relation to the large economic benefits of a number of large multinational corporations.

The PHM, through the relevance of its agenda, has succeeded in bringing together a large diversity of people, groups and networks from health, social justice and other backgrounds, but many members have higher ambitions still. The PHAs have been successful in bringing different groups together and this initiative is highly appreciated as such. Interviews and case studies in this evaluation demonstrate the long term impact that such a meeting can have to connect people, empower people, and make change. PHM members would like to see more dedicated effort to ensure participation at all levels in the movement of more women, younger generations, grass roots activists and others who are currently under represented. Some circles of PHM have succeeded in this better than others, but especially in global governance action is needed.

There is definitely appreciation for PHMs advocacy initiatives at the global level by partners in governments, international organizations such as WHO, and (international) non-governmental organizations and networks. These achievements are not well communicated to the rest of the movement and do not resonate much in the PHM initiatives that take place at national and local levels. Local and national PHM activists do not feel their voice is heard much at the global level, and not everyone sees the relevance of putting too much effort into the global level advocacy. Local and global PHM advocacy initiatives currently seem to lack interconnectedness. Regional coordination and country-to-country communication is weak and therefore important network opportunities are lost.

2. ***To which extent have the current PHM global programs, thematic circles, and other activities achieved the strategic objectives and respond to the PHM mission?***

Over the past years the movement has had a number of global campaigns and programmes, such as the Right to Health Campaign, the International People´s Health University, the Global Health Watch, and the WHO Watch (or 'Democratizing Global Health Governance'). These programmes have raised the profile of PHM and its visibility in the international arena. The Right to Health Campaign and IPHU have reached out to new people and groups and been strong vehicles for the dissemination of knowledge and formation and build capacity of young and new activists. The Global Health Watch receives strong appreciation from international activists, academics and government officials and shares people-centered analysis and perspectives on a wide variety of topics related to 'health for all'.

Thematic circles seem to have functioned less well, and it is actually unclear which thematic circles exist and are functional. Some previous thematic circles have gone through some adjustments and are now considered global programmes, like WHO Watch. PHM partners with the World Social Forum in the vision that 'another world is possible'. With some regularity, PHM manages to get articles published in peer reviewed publications such as the Lancet (products of the thematic circle on research) and at many important international conferences and events related to the right to health PHM now plays a role in organizing the event, organizing a session, or presenting in a session.

Communication tools like the PHM-Exchange and PHM websites play an important role in sharing information and supporting networking. The People's Health Assemblies, taking place once in every five years, provide the largest PHM platform for giving voice to those rarely heard, for sharing knowledge and joint strategizing.

The current global programmes and other activities of PHM have been less successful in ensuring the activities have a strong grass roots base and maintain strong grass roots linkages. Many country circles of PHM are not aware of PHM global activities, and although they could look up much of the information on the PHM website, the 'connection' is often lost to them with their actions and priorities. There is also in many cases a gap in the linkages and communication between global programmes and PHM at regional levels, especially Latin America which has a relatively strong regional PHM. Some people question the linkages between PHM

programmes, although they are all connected in their contribution towards the People's Charter for Health.

Programmes like the Right to Health Campaign and IPHU have great potential in reaching out to new and younger activists in countries that did not already have strong PHM presence, but many opportunities are lost due to lack of long-term planning and follow-up opportunities for those interested in PHM. An ongoing obstacle for long-term planning is the funding situation: limited availability of funds and usually no long-term security.

Many global programmes, such as the IPHU, Right to Health Campaign, and Global Health Watch, incorporate some gender analysis but many participants would like to see this come out much stronger. Responses from country circles suggest that perhaps there is more PHM activity taking place around gender than is known at global level, but this is not mirrored or supported by the global programmes and activities.

3 *To which extent has the current governance structure (including the management system and financial controls) enabled the movement to achieve reasonable levels of inclusiveness and transparency?*

Supporting and coordinating a global movement is not an easy task. A small group of committed individuals – most of them on a volunteer basis - has put in enormous efforts over the years to support the movement at a global level through fundraising, financial administration, documentation, website development and maintenance, development and dissemination of information materials and communication tools, translations, and lots and lots of e-mailing, phoning and Skyping. These individuals come from diverse backgrounds and different regions but they are united by the core values of the PHM. Their different realities, priorities, interests, skills, cultures and practices can form a challenge to work together at the global level, in addition to the geographical distance (with different time zones) and language differences that they need to overcome to simply communicate with each other.

There is overall agreement within the Steering Council that it is not functioning optimally, but solutions are more difficult to agree on. On the one hand, the current process and structure of PHM global governance poses challenges in relation to representativeness. The lack of accountability and lack of enforcement of a term limit allows people who are not actually participating in the SC to stay in the SC. Limited and ineffective communication within the SC, between the SC and the CoCo and the rest of the PHM (including Country Focal Persons) leads to misunderstandings, under appreciation and lack of transparency within the movement. PHM members currently do not know how and on what basis decisions are made at global level, for example about how money is spent and who gets to go to international meetings representing PHM. It is worrying that even some SC members did not feel sufficiently informed, although these members generally also admit to not 'staying on top of it' themselves because they are overstretched or unmotivated.

There is recognition within the Movement of there being a generation gap in the leadership, and a need to include more women and marginalized groups in the

leadership of PHM. Although it is crucial that the existing action plan for a new governance structure is implemented as planned leading up to the People's Health Assembly in 2012 (PHA3) further discussions on how to actively involve women and marginalized groups in the leadership is needed. Considering gender balance and a balance between more and less experienced members are mentioned in terms of the internal SC elections for the CoCo, but nowhere else.

PHM has managed to sustain a Global Secretariat throughout the years, and rotated the Secretariat around different PHM members, in different countries, and in different regions. PHM depends on the support and trust of the PHM member organization that functions as host for PHM, while simultaneously hoping that hosting the PHM Global Secretariat will also benefit the work of the host organization. The current three Global Secretariats are well coordinated and many within PHM who are aware of this (many people only know about the Global Coordinator and not about the Secretariat structure around her) appreciate the new structure. There are some concerns about the current spending of core funding to support all these Secretariats and staff positions, although people who are not actually part of the Steering Council generally have no idea how PHM is funded and what funds are spent on. Concerns have also been raised repeatedly from Latin America that they would like to see a Global Secretariat hosted in their region.

In general, PHM is a relatively large movement in Latin America but - even though Latin America is represented in the Steering Council and the CoCo – the relations between PHM Latin America and PHM Global are a cause for concern. There is need to increase and improve the communication and build the trust between them.

Financial controls and transparency have greatly improved in recent years, with agreements now clarified in MoUs and a financial policy approved by the SC.

4 How effective are the current PHM strategies for managing the sustainability of human and financial resources?

PHM is very effective in piggybacking on other events and in its use of resources. The number of paid staff is kept to a minimum. However the lack of regional administrative coordinators is making the management of human resources less than optimal. PHM today is relying on just a small group of dedicated individuals, most of them belonging to the 55+ generation and most of them having been part of PHM (nearly) from the beginning. The proposed new global governance structure, to be implemented in 2012, does propose limits to how long people can stay in global governing bodies of PHM and an Advisory body is suggested to promote that people with relevant experience can still be called upon. Most of the programmes as well as the PHM-Exchange depend heavily on just one or two PHM members, which is a risk factor and a lost opportunity to get more PHM members involved. The website development and maintenance, which is done by a team involving members from different parts of the world, is a notable exception.

IPHU has been one of PHM´s most important activities in the last years, but the lack of follow -up and concrete opportunities for alumni to get involved in PHM make it not achieve its potential in recruiting active members, even though many IPHU respondents admit to wanting to play a (bigger) role in PHM. A notable exception is

the African regions which has had the financial resources for a designated person to coordinate follow-up activities. Similar results are expected in other regions if resources were available.

There is need for more clarity in terms of who raises funds for what. PHM country circles need to raise their own funds, but some have received seed money through the Right to Health Campaign. Although there is strong appreciation for volunteer work and it is considered normal that members of the movement should contribute something to joint meetings and activities throughout the network, lack of funding is considered a challenge across the board. Changes in donor priorities and economic crises which decrease development funds that are made available pose real threats to the longer term financial sustainability of the network. Donor requirements like log frames and quantitative targets often fit poorly with the realities and dynamism of movements and networks, as experienced by PHM in many countries and regions. .

5 Is the current geographical spread pertinent to carrying out the PHM mission?

PHM has a presence in all regions of the world. Many of those active in PHM work at the grass roots and PHM is therefore able to represent grass roots community health movement. There is, however, still considerable potential to develop global links between grass roots health movements. The 'presence' in countries is not always at grass roots levels but can also be concentrated on academicians. Regional coordination is lacking in most regions and there is a lack of planning. Language forms an obstacle for communication between regions, between countries and also within countries. Much effort is already put into translating many PHM documents and web pages into Spanish, French and Arabic (besides English), but the quality of (volunteer) translations and speed of translations are still cause of concern for some members. The digital divide is an important consideration when aiming to bring out the voices of the poor and marginalized, especially since much of PHMs international and even national work relies heavily on online communication.

India and Latin America seem to be the strongest regions, although a decline in activities has been reported from India. Latin America has functioned quite independently from PHM in other regions and at the global level. The movement in Africa is young and less established, but through the Right to Health Campaign and IPHUs in the region as well as support from a part-time position at the Global Secretariat to build the movement in Africa many new circles have been started. There is also currently a huge amount of work going into mobilization towards PHA3 which is anticipated to further strengthen PHM in region.

In other regions the movement is patchy and is often represented by a few dedicated individuals who have direct contact with the global level. In some countries, PHM at country level is actually an already existing network or coalition on health that considers itself a partner of PHM without calling itself PHM.

Resources are needed for regional coordination and for strengthening linkages and there is need to prioritize funding within PHM for movement building.

6 To which extent is the PHM recognized as a global actor for change?

PHM has a genuinely good reputation globally in the spaces where it is active. The messages 'resonate'. PHM is known for its influence in the WHO Commission of Social Determinants and presence at the World Health Assemblies. The Global Health Watch is well recognized with WHO, health NGOs and some governments. Various other PHM publications, as well as its articles in publications like the Lancet, contribute to the visibility of PHM and the promotion of the message of 'Health for All'. PHMs analysis and health activism is also increasingly incorporated into medical and health education and taken up by lecturers and students.

However, global activities are not always grounded at a local level and the balance between 'global' and 'local' (or grass roots) needs to be better managed. As one of the founding members expressed it "We have an established global profile, but our image exaggerates our size. PHM punches above its weight."

CHAPTER 10: SUGGESTIONS AND RECOMMENDATIONS

The following chapter synthesizes the recommendations that follow from the preceding analysis of PHM as conducted by the evaluation team. These are suggestions which the evaluation team believes will strengthen PHM´s impact as a global actor for change. Many of these recommendations actually come from within the Movement and have been shared during the process of this evaluation by PHM members across the globe.

The previous evaluation from 2004 concluded that *"Above all, the pictures they drew [members of PHM] were a celebration of diversity and it is that diversity that is the main strength of PHM. Sustaining and maintaining a diverse, flexible and effective movement that serves as a platform for social change is the challenge that now faces PHM"*. It is also where we choose to start as we believe it is still a priority for PHM that requires still more emphasis and attention. It is the basis for the movement´s future.

We also cover recommendations related to the areas of planning, communication, and the local-global interface.

- **To increase the breadth and depth of PHM as a movement and strengthen its internal diversity.** Globally, this means identifying ways to better represent the diversity of the movement in its governance structures, priorities, campaigns and working groups. In the regions it involves increasing outreach to other movements, activists and academics who share PHM core values and vision, and who can develop other activities which are not seen as priorities by current PHM members. Given the universal appeal to the right to health, new or strengthened alliances can also be made with other kinds of movements: in particular global, regional and local environmental movements, indigenous, peasant and women's movements, as well as an emphasis on youth. Concrete activities that bring together different countries and regions would naturally bring different strands of PHM together. Communication needs to be improved within PHM between countries, in regions, and with PHM global as relevant. **IPHUs have a great potential to support movement building** by providing courses focusing on collective activism and advocacy.

  To embrace diversity is essential for ensuring a credibility as well as sustainability. It is important to consciously guard against sectarianism and exclusivism.

- **The governance structures – from the Steering Council to the state and district level coordination committees should be reviewed.** It is essential to keep the secretariat functions and ensure the capacity for strategic fundraising. The governance processes and representation should however be more inclusive and transparent. These may include time bound representation and processes for systematic feedback to ensure wider involvement and participation in PHM decisions. Gender balance and grass root representation at all levels should be sought. Some respondents highlight the need to ensure that the 'people's movement' character of PHM is reflected more strongly in the global PHM Steering Council. Currently, a few respondents articulated, the

council comprised of persons who are very committed, experts in their own rights and perfectly capable of providing "intellectual critique" but there is need to include others who are part of grassroots processes. Transparent, rotational processes should be put in place to ensure that the composition of the steering council is expanded and includes southern representation and identities. A new governance structure has already been developed, to be implemented in 2012, but to the extent that the above suggestions are not included this could still be adjusted as deemed relevant. Publishing clear and succinct information about the governance structure on the PHM website could contribute to a better understanding and greater transparency of the Movement's governance within its membership and partners. Some PHM 'circles' (in their broadest definition) would like to see more support and guidance from PHM Global, others would consider this unwelcome interference. It is a challenge to find the right tone that works for everyone, but more (and more personalized) communication is the way forward rather than less communication.

- **Outreach and support to share and renew leadership.** PHM Global (the SC but also the programmes) depends heavily on a relatively small group of people who have been with PHM mostly from the start. A system of 'mentoring' or 'coaching' could provide opportunities for newer and younger PHM members to be active while still receiving support from more experienced members. A policy to always bring along a more experienced and a less experienced PHM member to international meetings when PHM is invited or presenting, is another way to build capacity and provide opportunities for new leadership to grow. Small 'circles' could be formed that request for interested individuals to join. The secretariat and programme groups should ask for involvement (see "call of interest" below) from the movement at large when they have work that needs to be done.

- **The Gender Committee that that was established in 2010 by the Steering Council should develop an action plan towards strengthening gendered perspectives and inclusion of marginalized issues and concerns.** While some of this is happening, a stock taking of PHM initiatives that provide spaces for this and potential ways should be assessed. This Committee should be prioritized more strongly by the SC and receive strong support from the Global Secretariat. To enhance inclusiveness and ensure opportunities are not missed, there could be a 'call of interest' to other PHM members (from outside the SC) to join the Gender Committee. To clarify expectations and support a division of labour within the Committee and with the SC and the Global Secretariat, a sort of ToR and a timeline might need to be developed for the Gender Committee.

- **To strengthen participatory strategic development and planning.** There will always be some conflicting interests and expectations of PHM members in terms of what actions PHM should prioritize, this is inherent to such a large network. Prioritizing strategies and actions (campaigns, programmes, IPHUs etc) at national and regional levels will be useful, along with processes to decide if and what role the PHM can play in other campaigns. Yearly plans

including the interests and priorities of PHM's diverse membership could be published on the website to enhance transparency and provide greater opportunities for activists to participate. It is also important to discuss/clarify how/when someone can speak 'on behalf of' PHM and when a campaign or activity can be called a "PHM campaign" or "PHM supported campaign".

Such planning would facilitate role for new comers. Interested IPHU alumni (and other new recruits) **need to be offered concrete projects and campaigns** to get involved in to make their participation in PHM active, meaningful and enduring. The African region has positive experiences of such involvement facilitated by the African regional coordinator.

- **Regional SC representatives need to be (s)elected and have support from staff** to work on outreach, networking and communication to support planning and activities including fundraising. The African experience of employing a regional outreach coordinator should be built on and implemented in other regions taking the different contexts into account. A system is underway to make the (s)election of Regional SC representatives more participatory, inclusive and transparent. Expectations of representatives should be clarified and communicated in the Movement and those not-performing should be replaced. Organizing Regional PHAs could contribute to Movement building and solidarity.

- **Environment and health**: PHM is well placed (both geographically and in composition) to carry out in depth, far-reaching research, awareness-building, campaigning, advocacy and social mobilising to curb devastating effects on the health of people, communities and environment of climate change and open pit mining and other transnational 'mega projects'. Campaigning on socio-environmental issues would help PHM to multiply and foster new alliances particularly with young people, environmental movements, indigenous peoples and affected communities. These thematic areas also benefit from linkages between countries and regions, further strengthening the sharing and networking within PHM.

- **Communication strategies for improved transparency.** Regular condensed meeting minutes from CoCo and SC should be made available with the possibility for anyone to add their ideas and opinion. It does not imply that decisions is made by everyone but that there is a transparency in decisions taken and that feed back can be given from those concerned. Information about the PHM – Charter / principles, activities, structure, functioning, etc. should be disseminated widely and made easily available on the website to fill the gap of information deficit that has emerged. While the internet / websites and more recently the IPHU have been able to do this to some extent, other modes of dissemination will also have to be identified to facilitate wider and collective involvement. PHM at the country and regional levels should deliberate ways in which this can be operationalised, taking into account different languages, capacities, and the digital divide.

- **Communiction strategies for improved networking.** In order to improve PHM communication within the network and with interested 'outsiders', PHM-

Exchange could be revamped. There is much appreciation of PHM Exchange, while at the same time there is a clear need for more efficient and effective communication to take place within the Movement. It doesn't matter that PHM Exchange is not limited to 'PHM members' but allows anyone interested to sign up. PHM Exchange already has a lot of traffic and adding more messages to the list serve might cause an information overload for many people instead of improving the information flow. Instead, a list serve could be established in which people can select ('tick') their areas of interest about which they wish to receive e-mails on the list serve. This could include thematic and geographic areas, but also PHM specific updates, jobs and trainings, funding opportunities, etc.

It is recommended to create a PHM Global **Communications Committee.** Building upon their experience, it is further recommended that this Committee be hosted in Latin America, with central PHM funds to ensure greater inclusion, active participation in and contribution to the global movement. The establishment of regional communication committees would further facilitate the communication flow with regional representatives connected to a Global Committee. In collaboration with the existing web team the Committee could enhance greater coordination regionally and in PHM globally through technological and electronic means, fomenting widespread communication strategies through interactive website, live transmissions, community radios, television on Internet, etc.This is an opportunity for enhancing much more widespread communication of and within PHM through new technologies, and 'Equipo Comunicándonos' timely, high quality and prolific production.

- **Initiate and promote opportunities for thematic discussions**, whether through separate email groups, small skype sessions or an internet discussion forum. These discussions should be specific in their focus and time bound. Even if many thematic circles have not been very active or productive, there is a clear interest in the movement to discuss issues through the sharing of (people based) evidence, good practices, and solidarity. Relevant individuals and groups can be requested to contribute with their experience or case. Interesting contributions could be linked to campaigns, courses, websites and publications of PHM as relevant. As a starting point, the evaluation team suggests attempting to establish a thematic discussion on the impact of mining, a topic that was brought up in Latin America, North America, and Asia during the interviews

- **Develop local strategies for influencing WHO and global health governance.** The new PHM initiative of WHO Watchers is promising. A more intensive "bottom – up" approach is emphasized in the PHM strategy paper, but needs global distribution to PHM members, so that people on all levels perceive PHM resources and needs adequately. PHM should increase emphasis on country circles (in its broadest definition) and lobbying with WHO country representatives as well as Ministries of Health. A global inventory of existing and planned local PHM activities will enable a discussion on which initiatives are useful for influencing health governance at different level. It is important to articulate strategies for how to use case studies and country experiences most effectively. In order for such a strategy to work, PHM global

needs to make continued and consorted efforts to communicate back to country circles what has been achieved (and what challenges remain) at global level and how country circles or other forms of PHM organization have contributed/ can contribute to the success.

Permanent PHM presence in Geneva (WHO Secretariat) would greatly facilitate WHO lobby. Since Geneva is the *de facto* centre for global health policy making, PHM should consider strengthening its permanent presence there as a long term goal. A regular and permanent global debate for lobbying health policy priorities needs to be established within PHM, to strengthen the sense of common purpose of PHM members. Communication needs to be improved and linkages strengthened with country level PHM work.

The current situation of PHM activity on global level has led to a situation, where PHM is reactive in most policy debates, while Primary Health Care and 'Health for All' were radically modern and proactive issues. The evaluation mission therefore recommends to PHM to establish some kind of "think tank" as permanent observer of selected priority policy themes. This activity needs to include academia.

Appendix 1

People's Health Movement

Global Secretariat

Health for ALL NOW!!

Terms of Reference

The overall goal of the 2010 evaluation is to enable sharper impact of the PHM as a global actor for change. This would be achieved partially through assessing current gaps and informing more effective strategies.

The evaluation is expected to address the following questions:

- Do the current strategic objectives of the 'organizational component' of the movement adequately respond to the movement's mission articulated by the People's Charter for Health and other strategic documents?
- To which extent have the current PHM global programs, thematic circles, and other activities achieved the strategic objectives (see Annex 1) and respond to the PHM mission? This includes assessment for the capacities, achievement, performance and organization of each program and thematic circles and provision of clear recommendation for needed changes. Internal and external communication system and tools (electronic and non-electronic) should be included in the assessment.
- To which extent has the current governance structure (including the management system and financial controls) enabled the movement to achieve reasonable levels of inclusiveness and transparency? Current initiatives to enhance the governance structure and the management and financial policies should be taken into consideration. The progress PHM has made towards gender mainstreaming should be addressed.
- How effective is the current PHM strategies for managing the sustainability of human and financial resources?
- Is the current geographical spread pertinent to carrying out the PHM mission? The assessment should provide clear strategies to enhance the PHM geographical spread and linkage with grassroots initiatives.
- To which extent is the PHM recognized as a global actor for change? Those objectives and questions are subjected to be refined through further consultation within the PHM but also with the evaluation team).

Methodology

The evaluation will be conducted by a team. The detailed methodology is to be developed by the evaluation team; however we expect that the following methods and tools will be essential:

- Intensive review of the PHM main documents.
- Collective and individual meetings with the PHM global structures (governing and executive bodies) including staff and volunteers.

- Visits to some of the countries in which PHM has presence in (the sample of countries should be selected to represent different regions/realities as well as different level of development of the PHM circles). During these visits, quantitative and qualitative techniques may be used including short questionnaires, rapid participatory assessment, focus group discussions, and interviews.
- Online questionnaires and teleconferences to reach wider range of targets and to reduce the costs.

The PHM global secretariat will provide the evaluation team with the needed materials in addition to assist the development of the electronic and non-electronic tools when needed.

Appendix 2

Interview guide – PHM steering council members

1. There have been many discussions about the governance structure of PHM and various changes have taken place.

   a. How do you feel about the current governance structure of PHM? (incl. CoCo, Steering Council, secretariats and coordinators, role of PHA and links/inclusiveness with circles/countries/programmes/networks/newer activists)

   b. How does the current structure support transparency?

   c. How would you like the governance structure of PHM to be sometime in the future? (Why? What are the challenges to get there?)

2. How are the communication-flows within the different areas of PHM?

3. Gender: Existing strategies? How many men and men are there in leadership positions? Are women's voices heard, and are their suggestions taken on board? What kinds of problems are there? Are women's interests and aspirations included in PHM demands at global level?

4. PHM wants to be a global actor for change.
   a. To what extent do you feel PHM is recognized as a global actor for change? (by whom, on what? Examples of achievements?)
   b. How do you feel PHM could be a stronger global actor for change?

5. Do you have recommendations for PHM?

Appendix 3

Regional and country case studies – aspects to cover (all might not be applicable in all cases or for all informants).
Information to be gathered by interviews with PHM members, other key informants and through document reviews.

- Who is involved in PHM (organisations, individuals)? Description of the actors at different levels of involvement. Is there a functioning and properly constituted steering or co-ordinating committee with a defined membership and executive (chair, treasurer, secretary) and how often does it meet? How many PHM circles are there in the country? Which regions/provinces are involved?

- PHM activities and strategies: Which PHM activities have taken place (Campaigns, IPHU, etc...)? Whish strategies are used? Challenges and strengths? Which results have these activities/strategies had?

- Is PHM recognised as an actor for change in the health field? By whom (locally nationally, regionally?; stories (by PHM members and ´third parties" in other organisations/government etc).

- Specific WHO related issues:

1. on the REGIONAL WHO LEVEL, where and how is PHM active? the Regional Committees of PAHO, AFRO etc...,or in in consultative meetings?
2. On country level, who from PHM and for what reasons do meet the WHO representatives and their country staff occasionally? or regularly?
3. Are their issues, lobbied for-, advocated by PHM, that "filter up" in the WHO institutional hierarchy? Who are the "message carriers"?
4. Finally: is WHO looking for PHM, or is it so far a one-way road?

- Sustainability (financial and human). Where is funding coming from? Strategies round funding? Are there new-comers to the movement? How are they getting involved?

- Country movement: Challenges and strengths? Can it be more effective? Which communication strategies exist?

- Regional coordination: Which form does it take; contacts with other countries (PHM circles); can it be more effective? Communication strategies?

- Role of the global secretariat (including communication): How does it work? Which role should they have? What is working well? Which challenges exists?

- Gender: Existing strategies? How many men and men are there in leadership positions? Are women's voices heard, and are their suggestions taken on board? What kinds of problems are there? Are women's interests and aspirations included in PHM demands? How do PHM publications, DVDs, etc. represent women?

- Marginalised groups: Existing strategies? How are they included in PHM?

- Recommendations in general: how can the movement be more effective?

PHM evaluation

1. Structure and characteristics

1. Please state your country

2. To which region do you belong?

- ◯ Africa
- ◯ South Asia
- ◯ India
- ◯ South East Asia
- ◯ Europe
- ◯ Central America
- ◯ South America
- ◯ Canada
- ◯ USA
- ◯ Middle East and North Africa
- ◯ Australia and Pacific
- ◯ Don't know

3. When did PHM start in the country?

- ◯ > 10 years ago
- ◯ 10-7 years ago
- ◯ 6-3 years ago
- ◯ < 2 years ago

4. Please describe the structure of PHM in your country (Coordination, decision making processes ? Executive committee? etc)

PHM evaluation

5. Is there a PHM circle in you country?

- ◯ Yes
- ◯ No

If yes, how many circles

6. How many individuals are actively involved in PHM in your country?

- ◯ 1-5
- ◯ 6-20
- ◯ 21-50
- ◯ 50-250
- ◯ >250
- ◯ Don't know

7. Does PHM have a national reach?

- ◯ Yes
- ◯ No

If not to which geographical area is it confined?

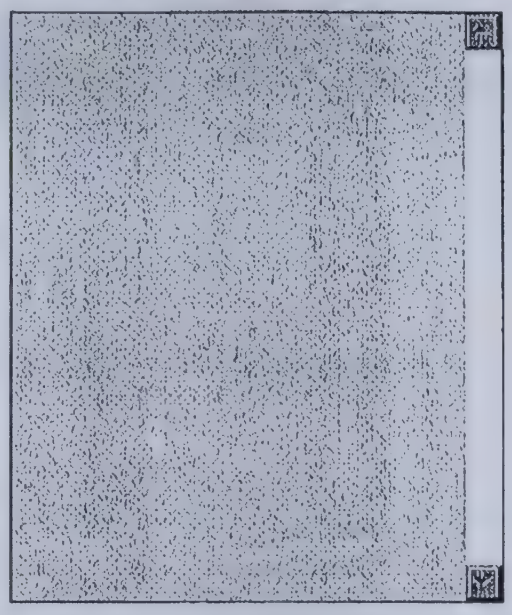
2. PHM activities

1. Has PHM in your country been invovled in the follwoing activities

	Yes	No
Hosted an IPHU course	◯	◯
Participated in the Right to Health Care Campaign	◯	◯
Contributed to the Global Health Watch	◯	◯
Participated in the Global Health Governance project	◯	◯
Setting up a web site	◯	◯
Other	◯	◯

Other (please specify)

2. Please reflect on main challenges and results of the activities PHM has been involved in on a country level



3. How do you consider the level of activity of PHM to be?

	Very active	Active	Regular	Passive	Don't know
In your country	○	○	○	○	○
In your region	○	○	○	○	○
Globally	○	○	○	○	○

4. How effective do you think the following activities are for achieving the Right to Health in your country?

	Very effective	Effective	Somehow effective	Not at all effective	Don't know
Campaigns and social mobilisation	○	○	○	○	○
Lobbying for changes in legislation and regulations at a national level	○	○	○	○	○
Contacts/lobbying with country and regional WHO representatives	○	○	○	○	○

PHM evaluation

5. How effective do you think the PHM has been in addressing the issues of gender and other marginalised groups in its campaigns and activities? Please elaborate on what strategies have been used in your country.

3. Contacts and Comunication

1. How often do you have contacts with

	>12 times/ year	6-12 times/ year	1-4 times/ year	< 1 time/ year	Don't know
PHM groups within the country	○	○	○	○	○
PHM groups/cirkles in the region	○	○	○	○	○
The Regional PHM coordinator	○	○	○	○	○
The Global Secretariats	○	○	○	○	○
Governmental officals in your country	○	○	○	○	○
WHO officials in your country/region	○	○	○	○	○

4. Achievments

1. How do you thinkg PHM achieves the following at a regional level

	Very well	Well	Regular	Not at all	Don't know
Have a good organisational structure	○	○	○	○	○
Share information on ongoing activities	○	○	○	○	○
Generate debate among its members	○	○	○	○	○
Listen to its members	○	○	○	○	○
Activities reflect the concern of its members	○	○	○	○	○
Influence policy	○	○	○	○	○

2. How do you think PHM achieves the following at a global level

	Very well	Well	Regular	Not at all	Don't know
Have a good organisational structure	○	○	○	○	○
Share information on ongoing activities	○	○	○	○	○
Generate debate among its members	○	○	○	○	○
Listen to its members	○	○	○	○	○
Activities reflect the concerns of its members	○	○	○	○	○
Influence policy	○	○	○	○	○

3. In your country do you think PHM is known among...

	Well known	Known	Little known	Not at all known	Don't know
The Ministry of Health	○	○	○	○	○
Non Governmental organisations	○	○	○	○	○
International organisations and movements	○	○	○	○	○
Others	○	○	○	○	○

Other (please specify)

4. What do you consider major achievements by PHM to be in your country

5. What do you consider major achievements by PHM to be in your region

PHM evaluation

6. What do you consider major achievements by PHM to be globally

5. Sustainability

1. Does PHM in your country receive financial and other support?

- ◯ Yes
- ◯ No

If yes, what are the sources?

2. Which are you main strategies for fundraising?

3. Are there new-comers to PHM in your country?

- ◯ Yes
- ◯ No

If yes, how are they recruited?

4. How do you work with volunteers? Please describe your strategies

6. Recommendations

1. Which are you recommendations for a more effective PHM in your country?

2. Which are you recommendations for a more effective PHM at a regional level?

3. Which are you recommendations for a more effective PHM at a global level?

Thanks for completing the questionnaire and contribute to the PHM evaluation 2011

Appendix 5

IPHU

5. Your role in the course

- ◯ faculty
- ◯ participant
- ◯ other:

Other (please specify)

6. How active are you in People's Health Movement (PHM)?
Please note, tick only alternative

- ◯ not at all
- ◯ on one occasion
- ◯ once or twice a year
- ◯ five or six times per year
- ◯ on a monthly basis
- ◯ on a weekly basis

if yes, describe your involvement

7. If you are active in PHM, for how long have you been engaged?

- ◯ Less than one year
- ◯ 1-2 years
- ◯ 3-4 years
- ◯ 5 or more

8. How did you get to know about the course arranged by IPHU?

- ◯ PHM Exchange
- ◯ From a colleague
- ◯ Leaflet
- ◯ Other

Other (please specify)

9. What motivated you to participate in a course arranged by IPHU?

10. Reflections on the IPHU course you participated in:

	Excellent	Good	Regular	Poor	No opinion
The organization of the course was	◯	◯	◯	◯	◯
The content of the course was	◯	◯	◯	◯	◯
The teaching methods were	◯	◯	◯	◯	◯
The venue of the course was	◯	◯	◯	◯	◯
The mix of student	◯	◯	◯	◯	◯
Quality of faculty and facilitators	◯	◯	◯	◯	◯

11. The goals and objectives for IPHU Short Courses are defined below. Do you perceive that these goals were met in the course you attended?

	yes	no	not applicable	no opinion
Learn practical skills and concepts which will enable me to be more effective as an activist in the people's health movement	◯	◯	◯	◯
Deepen my understanding of globalisation and the political economy of health	◯	◯	◯	◯
Learn more about health services policy, about comprehensive	◯	◯	◯	◯
primary health care and about health systems	◯	◯	◯	◯
Explore the application of a rights-based approach to health issues	◯	◯	◯	◯
Learn about "development assistance" in health and about the politics of "health sector reform"	◯	◯	◯	◯
Broaden my understanding of the links between the environment and health	◯	◯	◯	◯
Work through the implications of gender relations in relation to health (and other axes of difference) and acquire new insights, skills and strategies addressing these issues	◯	◯	◯	◯
Learn more about the social determinants of health and the role of the health sector in addressing these	◯	◯	◯	◯
Explore the role of meaning and spirituality in activism and social change	◯	◯	◯	◯

12. Summarize your experiences of the teaching and learning from the course:

13. Were your expectations of the course met?

◯ yes ◯ no ◯ no opinion

Comments:

14. Were there things you lacked in the course?

◯ yes ◯ no ◯ no opinion

Comments:

15. How do you think IPHU contributes to the movement of PHM?

16. Do you have contact with the people in the course(s) you participated in?

◯ yes ◯ no

If yes, please describe on-going contacts and/or collaborations

17. Were you active in PHM before you participated in the course?

◯ yes ◯ no

18. Did your participation in the course change your engagement in the PHM?

◯ yes ◯ no

I yes, specify how:

19. Would you like to be more involved in PHM than you are?

◯ yes ◯ no ◯ no opinion

20. Have members of PHM been in touch with you since the course and offered you ways of being involved in PHM?

◯ yes ◯ no ◯ don't know

I yes, specify how:

21. Has the course been useful for other activities than PHM (for your work, volunteer work etc)?

◯ yes ◯ no ◯ no opinion

If yes, explain how:

22. What are your recommendations for a more effective IPHU?

Thank you very much for completing this survey, your answers are valuable for the evaluation of the IPHU courses

Appendix 6

Survey to PHM focal points and country representatives

1. To which region do you belong?

	Response percent	Response count
Africa	**28.5%**	**10**
South Asia	8.5%	3
India	0.0%	0
South East Asia	17.1%	6
Europe	14.3%	5
Central America	2.8%	1
South America	11.4%	4
Canada	2.8%	1
USA	0.0%	0
Middle East and North Africa	5.7%	2
Australia and Pacific	8.6%	3
Don´t know	0.0%	0
	Answered questions	35
	Skipped questions	1

2. When did PHM start in the country?

	Response percent	Response count
> 10 years ago	**32.3 %**	**11**
10-7 years ago	14.7 %	5
6-3 years ago	29.4 %	10
< 2 years ago	23.5 %	8
	Answered questions	34
	Skipped questions	2

3. Is there a PHM circle in your country?

	Response percent	Response count
Yes	**66.6 %**	**22**
No	33.3 %	11
If yes, how many circles?		19
	Answered questions	33
	Skipped questions	3

4. How many individuals are actively involved in PHM in your country?

	Response percent	Response count
1-5	17.6 %	6
6-20	26.5 %	9
21-50	**32.3 %**	**11**
50-250	8.8 %	3
> 250	8.8 %	3

Don´t know	5.8 %	2
	Answered questions	34
	Skipped questions	2

5. Does PHM have a national reach?

	Response percent	Response count
Yes	38.5 %	13
No	**61.8 %**	**21**
	Answered questions	34
	Skipped questions	2

6. Has PHM in your country been involved in the following activities:

	Affirmative percent	Response count
Hosted an IPHU course	30.0 %	30
Participated in the Right to Health Care campaign	57.1 %	28
Contributed to the Global Health Watch	24.0 %	25
Participated in the Global Health Governance project	25.9 %	27
Setting up a website	32.0 %	25
Other	77.7 %	18
	Answered questions	30
	Skipped questions	6

7. How do you consider the level of activity of PHM to be?

	Very active	Active	Regular	Passive	Don´t know	Response count
In your country	6.4 %	22.5 %	**35.5 %**	32.2 %	3.2 %	31
In your region	6.4 %	29.0 %	**32.2 %**	16.1 %	16.1 %	31
Globally	23.3 %	**33.3 %**	20.0 %	16.6 %	6.6 %	30
				Answered questions		31
				Skipped questions		5

8. How effective do you think the following activities are for achieving the Right to Health in your country?

	Very effective	Effective	Somehow effective	Not at all effective	Don´t know	Response count
In your country	**35.5 %**	32.2 %	29.0 %	0.0 %	3.2 %	31
In your region	32.2 %	**35.5 %**	29.0 %	0.0 %	3.2 %	31
Globally	23.3 %	**26.6 %**	23.3 %	13.3 %	13.3 %	30
				Answered questions		31
				Skipped questions		5

9. How often do you have contacts with

	>12 times/year	5-12 times/year	1-4 times/year	<1 time/year	Don´t know	Response count
PHM groups within the country	**33.3 %**	18.5 %	18.5 %	22.2 %	7.4 %	27
PHM groups/circles in the region	18.5 %	14.8 %	**22.2 %**	**22.2 %**	**22.2 %**	27
Regional PHM coordinator	26.9 %	7.7 %	15.4 %	15.4 %	**34.6 %**	26
Global Secretariats	19.2 %	**23.0 %**	**23.0 %**	19.2 %	15.4 %	26
Government officials in your country	32.1 %	7.1 %	**39.2 %**	14.3 %	7.1 %	28
WHO officials in your country	15.4 %	3.8 %	30.7 %	**30.7 %**	19.2 %	26
				Answered questions		29
				Skipped questions		7

10. How do you think PHM achieves the following at a regional level

	Very well	Well	Regular	Not at all	Don´t know	Response count
Good organizational structure	3.6 %	**25.0 %**	21.4 %	39.3 %	10.7 %	28
Share information	**35.7 %**	7.1 %	25.0 %	25.0 %	7.1 %	28
Generate debate	14.3 %	10.7 %	28.6 %	**32.1 %**	14.3 %	28
Listen to its members	18.5 %	18.5 %	14.8 %	22.2 %	**25.9 %**	27
Activities reflect concern of its members	18.5 %	11.1 %	18.5 %	**29.6 %**	22.2 %	27
Influence policy	11.5 %	19.2 %	23.0 %	**38.5 %**	7.7 %	26
				Answered questions		28
				Skipped questions		8

11. How do you think PHM achieves the following at a global level

	Very well	Well	Regular	Not at all	Don´t know	Response count
Good	17.8 %	**42.8 %**	28.6 %	3.6 %	7.1 %	28

organizational structure						
Share information	35.7 %	**39.3 %**	21.4 %	3.6 %	0.0 %	28
Generate debate	14.3 %	**42.8 %**	39.3 %	0.0 %	3.6 %	28
Listen to its members	18.5 %	**44.4 %**	22.2 %	0.0 %	14.8 %	27
Activities reflect concern of its members	14.3 %	**32.1 %**	**32.1 %**	3.6 %	17.8 %	28
Influence policy	17.8 %	**39.3 %**	32.1 %	3.6 %	7.1 %	28
				Answered questions		28
				Skipped questions		8

12. In your country do you think PHM is known among …

	Very well known	Known	Little known	Not at all known	Don´t know	Response count
Ministry of Health	10.7 %	14.3 %	**42.8 %**	32.1 %	0.0 %	28
Non Governmental Organizations	14.3 %	**42.8 %**	32.1 %	10.7 %	0.0 %	28
International org. and movements	3.7 %	37.0 %	**40.7 %**	18.5 %	0.0 %	27
Others	14.3 %	21.4 %	**28.6 %**	14.3 %	21.4 %	14
				Answered questions		28
				Skipped questions		8

13. Does PHM in your country receive financial and other support?

	Response percent	Response count
Yes	10.7 %	3
No	**89.3 %**	**25**
	Answered questions	28
	Skipped questions	8

14. Are there new-comers to PHM in your country?

	Response percent	Response count
Yes	**65.4 %**	**17**
No	34.6 %	9
	Answered questions	26
	Skipped questions	10

Appendix 7

Survey to IPHU alumni and faculty

1. Course site(s) where you participated in the IPHU course(s)

	Response percent	Response count
Dakar, Senegal 2011	10.5 %	12
Moratuwa, Sri Lanka 2010	10.5 %	12
Kisumu, Kenya 2010	14.0 %	16
Chimatenango, Guatemala 2010	**14.9 %**	**17**
Londres, UK 2010	4.4 %	5
La Havana, Cuba 2009	13.1 %	15
Bangalore, India 2009	9.6 %	11
Thessaloniki, Greece 2009	1.7	2
London, UK 2009	4.4 %	5
Porto Alegre, Brazil 2008	6.1 %	7
Jaipur, India 2008	6.1 %	7
Cairo, Egypt 2008	6.1 %	7
Savar, Bangladesh 2007	10.5 %	12
Atlanta, USA 2007	2.6 %	3
Vancouver, Canada 2007	1.7 %	2
Bhopal , India 2007	3.5 %	4
Cuenca, Ecuador 2005	7.9 %	9
	Answered questions	114
	Skipped questions	2

2. Do you belong to an ethnic minority?

	Response percent	Response count
Yes	21.0 %	24
No	**72.8 %**	**83**
Don´t know	6.1 %	7
	Answered questions	114
	Skipped questions	2

3. Your age

	Response percent	Response count
Below 21 years	0.0 %	0
Between 21-30 years	35.6%	41
Between 31-40 years	**37.4 %**	**43**
Between 41-50 years	17.4 %	20

Over 51years	9.6 %	11
	Answered questions	115
	Skipped questions	1

4. Your role in the course

	Response percent	Response count
Faculty	10.9 %	12
Participant	**76.4 %**	**84**
Other	3.6 %	4
	Answered questions	110
	Skipped questions	6

5. How active are you in the PHM? Please, note, tick only one alternative

	Response percent	Response count
Not at all	13.4 %	15
On one occasion	**22.3 %**	**25**
Once/twice a year	17.0 %	19
Five/six times per year	16.0%	18
On a monthly basis	9.8 %	11
On a weekly basis	21.4 %	24
	Answered questions	112
	Skipped questions	4

6. If you are active in PHM, for how long have you been engaged?

	Response percent	Response count
Less than one year	15.9 %	15
1-2 years	**34.0 %**	**32**
3-4 years	18.0 %	17
5 or more	31.9 %	30
	Answered questions	94
	Skipped questions	22

7. How did you get to know about the course arranged by IPHU?

	Response percent	Response count
PHM exchange	27.2 %	28
From a colleague	**46.6 %**	**48**
Leaflet	0.97 %	1
Other	25.2 %	26

	Answered questions	103
	Skipped questions	13

8. Reflections on the IPHU course you participated in:

	Excellent	Good	Regular	Poor	No opinion	Response count
Organization	36.0 %	**54.4 %**	7.9 %	1.7 %	0.0 %	114
Content	**44.7 %**	42.1 %	10.5 %	2.6 %	0.0 %	114
Teaching methods	27.8 %	**53.9 %**	13.0 %	5.2 %	0.0 %	115
Venue	33.3 %	**43.8 %**	20.2 %	2.6 %	0.0 %	114
Mix of student	**52.2 %**	36.3 %	11.5 %	0.0 %	0.0 %	113
Quality faculty	43.2 %	**48.6 %**	8.1 %	0.0 %	0.0 %	111
				Answered questions		115
				Skipped questions		1

9. The goals and objectives for IPHU Short Courses are defined below. Do you perceive that these goals were met in the course you attended?

	Yes	No	Not applicable	No opinion	Response count
Learn practical skills and concepts which will enable me to be more effective as an activist in the PHM	**73.4 %**	18.6 %	2.6 %	5.3 %	113
Deepen my understanding of globalisation and the political economy of health	**92.9 %**	6.2 %	0.0 %	0.9 %	113
Learn more about health services policy; about comprehensive primary health care and about health systems	**73.7 %**	14.9 %	2.6 %	5.3 %	114
Explore the application of a rights-based approach to health issues	**83.2 %**	9.7 %	3.5 %	3.5 %	113
Learn about "development assistance" in health and about the politics of "health sector reform"	**69.0 %**	22.1 %	1.8 %	7.1 %	113
Broaden my understanding of the links between the environment and health	**71.0 %**	21.9 %	2.6 %	4.4 %	114
Work through the implications of	**60.5 %**	32.4 %	4.4 %	2.6 %	114

gender relations in relation to health (and other axes of difference) and acquire new insights, skills and strategies addressing these issues					
Learn more about the social determinants of health and the role of the health sector in addressing these	**90.3 %**	8.8 %	0.9 %	0.0 %	113
Explore the role of meaning and spirituality in activism and social change	**59.4 %**	24.3 %	4.5 %	11.7 %	111
			Answered questions		114
			Skipped questions		2

10. Were your expectations of the course met?

	Response percent	Response count
Yes	**83.2 %**	**94**
No	12.4 %	14
No opinion	4.4 %	5
	Answered questions	113
	Skipped questions	3

11. Were there things you lacked in the course?

	Response percent	Response count
Yes	**56.1 %**	**60**
No	29.0%	31
No opinion	14.9 %	16
	Answered questions	107
	Skipped questions	9

12. Do you have contact with the people in the course(s) you have attended?

	Response percent	Response count
Yes	**91.2 %**	**104**
No	8.8%	10
	Answered questions	114
	Skipped questions	2

13. Were you active in PHM before you participated in the course?

	Response percent	Response count

Yes	33.9 %	39
No	**66.1 %**	**76**
	Answered questions	115
	Skipped questions	1

14. Did your participation in the course change your engagement in the PHM?

	Response percent	Response count
Yes	**64.1 %**	**68**
No	35.8 %	38
	Answered questions	106
	Skipped questions	10

15. Would you like to be more involved in PHM than you are?

	Response percent	Response count
Yes	**83.2 %**	**94**
No	5.3 %	6
No opinion	11.5 %	13
	Answered questions	113
	Skipped questions	3

16. Have members of PHM been in touch with you since the course and offered you ways of being involved in PHM?

	Response percent	Response count
Yes	**63.3 %**	**69**
No	30.3 %	33
Don´t know	6.4%	7
	Answered questions	109
	Skipped questions	7

17. Has the course been useful for other activities than PHM (for your work, volunteer work etc)?

	Response percent	Response count
Yes	**83.3 %**	**95**
No	8.8 %	10
No opinion	7.9 %	9
	Answered questions	114
	Skipped questions	2

Appendix 8

Report on Ecuador

Morna Macleod
May 2011

Introduction

This section is based on a fieldtrip to Ecuador (4 days in Cuenca, 1 in Guayaquil and 1 in Quito), 13 interviews (6 women, 11 men), a collective meeting with women and men affected by mining concessions in Kimsacocha, Tarqui y Victoria de Portete, and a visit to San Bartolo in Azuay, where previous damages caused by mining have created widespread community resistance to new mining concessions to Canadian corporations. The report also draws on the 2010 evaluation of PHM-LA and review of some documentation and websites.

Context

Ecuador has a long history of powerful social movements; indeed the indigenous movement has on various occasions paralysed the country through massive uprising and roadblocks and toppled governments. President Rafael Correa's government promised to bring about XXI socialism. After a landslide victory, a promising start was made with vast civil society participation including drawing up one of Latin America's most innovative and far-reaching constitutions (together with Bolivia's). This includes not only human and indigenous rights, but also **the rights of nature** and the *pachamama* (mother earth), and *sumak kawsay* or 'buen vivir' (quality of life) which questions western modernity and development paradigms. Ironically, Correa's second term in office has witnessed growing disillusion and confrontation with social movements, including indigenous, health-workers and students. Issues concerning new water and mining laws are particularly contentious, as these differ greatly from the spirit enshrined in the 2008 constitution, opening the country up to further privatisation and concessions to international corporations. Social protest in particular around water, open-pit mining has led to opposition to the government, which is being criminalised with alarming cases of social activists being imprisoned and accused of terrorism. Apart from the traditional right, progressive and left-wing civil society is split between Correa supporters and detractors, with risk of further polarisation. In the recent referendum (7/5/2011) for legal and constitutional reforms, rather than another landslide victory giving massive support to Correa, a narrow 'yes' in support of the proposed reforms narrowly defeated the 'no' from the right and 'not this time' from dissatisfied progressive sectors.

After the stunning victory of getting 60-70% of health-coalition (including PHM) demands and perspectives into the constitution, these gains are yet to materialise, given the lack of an organic health law to implement changes. Health policies continue to be bio-medic and infrastructure-oriented: *"It's great that Correa has curbed deterioration, saved the social security system and invested a lot of money in health and education. But when we analyse the **quality** and the **model** of social spending, it's totally traditional. The huge 'boost' in funds favours large corporations... The **health model** needs to be discussed, and whether what is happening is not a hidden form of privatisation"*. A recent spate of neonatal deaths in hospitals in Guayaquil has caused outcry and is, according to interviews, a reflection of current health policies. Rather than spending on human resources and seeking greater coverage and quality attention, funds are overwhelmingly going into building hospitals (US $450), purchasing equipment and medicines (the pharmaceutical industry spent $25 million in advertising in 2010). Bonuses for vulnerable groups foment political clientelism,

but provide no long-term solutions to the country's pressing health problems. In sum, the most likely scenario bodes for further conflict, social unrest and political instability.

PHM in Ecuador

- **II Peoples' Health Assembly (Cuenca)**

In Ecuador PHM has its origins in 1998 with preparations for the 2000 People's Health Assembly in Savar, bringing together social health activists with long-term professional and social trajectories. Organising the II PHA gave rise to forming the health coalition National Front for Peoples' Health Ecuador (FNSPE) in 2004, and Equipo Comunicándonos (EC) to communicate and disseminate the Assembly. EC has become a crucial component for movement building not just in Ecuador but in the whole of Latin America. The year spent preparing the II PHA propitiated close collaboration between a variety of grassroots organisations and movements, scholars, researchers, artists and social activists. The II PHA and IPHU in Cuenca (as the Savar PHA before) had a great impact on many in personal and organisational terms. Themes included health and poverty, militarisation, environmental degradation, indigenous knowledge and intercultural health, and bringing 'joy' (alegría) and 'fun' on board as essential elements for health. The Assembly set the example that 'another health is possible'. 1,492 delegates from 82 countries registered for II PHA, though some estimate that as many as 5,000 people took part one way or another (400 musicians and indigenous dancers, concerts, free sessions for massage and alternative healing, etc.). The significant impact of the II PHM gave an impulse to subsequent coalition-building and advocacy work around the new constitution.

- **Vision and shared values and principles**

Without a doubt, what brings people and movements together in Ecuador are shared visions and values set out in the Declaration of Cuenca: "*The vision endorsed at PHA2 is for a socially and economically just world in which peace prevails; a world in which all people, whatever their social and economic condition, gender, cultural identity and ability, are respected, are able to claim their right to health and celebrate life, nature, and diversity*". Joint vision also involves people from the medical profession, scholars, researchers and activists all working hand-in-hand with the grassroots: indigenous communities, rural and urban workers, housewives, shanty-town dwellers, etc., ensuring peoples' agency and contributing to empowerment and struggles for social justice. Leading lights in the movement represent some of the best Latin American tradition of scholars with hands-on practice and collaboration with social movements and communities, and getting grassroots perspectives into academia, through participatory research-action, testimony and multimedia. Multidisciplinary approaches also provide innovating ways of working.

- **Coordination and coalitions**

Given that PHM-Ecuador does not have a formal structure or membership, coalitions, people and their institutions have a fluid relationship with PHM: "*sometimes we contribute from outside, sometimes we're inside like during the II Assembly, which was an intense collective process with lots of participation*". Then, too, key leaders wear several hats, for example, Dr. Arturo Quizhpe is the Dean of the Faculty of Medical Science at the University of Cuenca, member of PHM CoCo, a key figure in PHM-LA, and ReAct Latin American Coordinator. Logos on documents and in public events is one way of ascertaining PHM presence.

The **National Front for Peoples' Health Ecuador (FNSPE)** was formed during the preparations for the II PHA and brings together health, teachers, women, youth and artist fronts. In the editorial of its first bulletin (2007) it explains: "*The FNSPE emerged after the First World Peoples' Health Assembly in Bangladesh in 2000. This world event and final declaration motivated organisations to be formed in*

Ecuador and other countries to form part of MSP/PHM, adhering to the Bangladesh Declaration. Thus FNSPE is born in 2002[43] *in Cuenca, bringing together every person and popular, academic and scientific organisations which share the common objective of achieving HEALTH" (Ricardo Ramírez, FNSPE President, editorial, Year One No.1, 2007: 2*). The quote is important, as it shows a very direct relationship with PHM (which is different, for example, to the Foro Salud in Peru, which includes PHM logo on its website, along with affiliations to other international movements and networks). FNSPE operates mainly in Guayaquil, meeting regularly, and with outreach to 14 provinces. It carries out public forums with scholars and activists, and numerous health activities (including pap tests for women), particularly in depressed urban and rural areas. FNSPE was recently outspoken in its critique of neonatal deaths in hospitals in Guayaquil.

Equipo Comunicándonos (EC): has consolidated since the II PHA in Cuenca. It's 5 objectives include: a) information dissemination, b) production of materials on health, social mobilisation around health, and changes in Ecuadorian health policies, c) educational materials (videos, books, radio series), which are distributed throughout Latin America, d) participatory communication, and e) formation of popular and community communicators. EC contributes to the PHM website in Spanish and disseminates Pijuano magazine etc. www.pijuano.blogspot.com (See Kraus Report, 2010). EC high quality and artistic creations –particularly videos- stand out amongst the vast production of communication materials by social movements in Latin America.

Whereas FNSPE and EC are clearly linked to PHM, others are close collaborators "*involved in the same struggle*", who sometimes participate 'from within' and sometimes 'from without'. These include the University of Cuenca's Faculty of Medical Science, the Andean Simón Bolivar University's Area of Health, ReAct, the Network for the Right to Health (which formed to influence the 2008 constitution on health perspectives and issues), *Campesino* Social Security and the Intercultural Coordination for Peoples' Health. While Acción Ecológica participated intensely in II PHA and was in charge of organising the part on Health and Environment, it no longer feels part of the PHM, as it considers that globally PHM is not working on priorities shared by AE or indeed the health movement in Ecuador. PHM-Ecuador also includes individual activists (or individuals who sometimes act alone and sometimes represent their member organisations). "*In Quito we feel part of the movement to a certain extent, or we consider ourselves to be allies, and in a way we are representatives of PHM. It's ambivalent, there's inertia as it hasn't been discussed and formalised*".

One critique is that the like-minded work together and the movement needs to be widened: "*The problem is not convincing the convinced, but of reaching out to others who aren't convinced. We need to find issues that bring us all together and that make people listen to us*". One person questioned the lack of ample process to decide upon who represents the movement and the need to ensure leadership rotation. On the up side, "*we share the same vision and lots of proposals, like intercultural health. There is a lot of work with the grassroots, and also academics. We've held high level meetings, for example, with the assembly members working on the new constitution*". Some mentioned the movement's peaks and lulls, and considered the present as a moment when "*we're asleep, though things are beginning to happen*". The loose and unstructured nature of PHM in Ecuador has its advantages and disadvantages, but there is a shared sense that pending discussions and debates need to take place, and that the movement needs to be more structured and resourced. Specifically, there needs to be a person in charge of coordinating, liaising and communicating with movement contacts in other countries (as there is in Central America). At present, there is only one staff person in South America in Equipo Comunicándonos and some support for administration. To this end, a meeting was planned for mid-May (after the consultant's visit) to discuss a variety of issues and initiatives.

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[43] Others say FNSPE was officially formed in 2004; most likely 2002 represents the first more informal coordination meetings, with FNSPE being formally launched a year before the II PHA.

Activities and Approaches to Health

PHM-Ecuador and allies work on a wide range of health issues and demands[44], and liaises with a variety of international universities, research initiatives (such as Teasdale Corti and Canadian universities) and networks (ALAMES, ReAct, etc.). Rather than a detailed list of activities, the following section explores two areas: a) Health and Environment, and b) Intercultural Health, given the cutting-edge, innovative nature of both. Short descriptions include PHM allies (or those who at times participate from 'within' and at times from 'without').

- **Health and environment**

In January 2007 PHM-LA together with the University of Cuenca's Medical Science Faculty, FNSPE, Acción Ecológica, the Popular *Campesina* Coordination and two local committees in the area organised a national event, the '*Peoples' Meeting for Life*' in Sigsig, an area affected by Canadian mining concessions. About 3,000 people participated in a series of activities including a march in defence of water. The **National Coordinator for the Defence of Life and Sovereignty** was formed on this occasion, bringing together about 20 community and indigenous organisations, students and FNSPE. This marks the beginning of a concerted effort to make mining and water issues top priorities for PHM in Ecuador. One way of supporting the new Coordinator has been for Equipo Comunicándonos to make numerous videos, books and other educational materials, which both help to raise awareness about the negative impacts of open pit mining on the environment and provide a small income for the coalition through the sale of the materials.

Currently a major **international** event is being organised in defence of "***Water and the Pachamama***", 21-24 June 2011 in Cuenca. Convened by 19 organisations including the PHM-LA and Equipo Comunicándonos, the meeting will denounce serious human rights violations (including the criminalising social of protest) and the rights of nature, holding an International Ethical Tribunal to consider the damages caused by the extractive industries and dispossession of water and indigenous territory. The event will also enhance exchange and analysis of different experiences and gather alternative proposals for new *Sumak Kawsay* paradigms: "*spirituality, solidarity, reciprocity and respect for the Pachamama* (mother earth)" (brochure 2011: 6). Themes to be discussed include: "*health, environment, water, biodiversity, food sovereignty, culture, human displacements and labour laws*" (ibid: 8). Cases of petrol exploitation will also be analysed. The event will look at "*transnational corporation strategies, social organisation and struggle, the sacred nature of water, resistance through aesthetics and communication (music, dance, films, video, theatre, murals, etc.)*" (ibid). This event clearly illustrates some of PHM's greatest priorities, strategies and allies at present.

Other creative cutting-edge experiences of PHM allies (sometimes from within, sometimes from without) in Ecuador include:

- **Regional Health and Environment Observatory**: with roots in various academic events on the social determinants to health organised by the Andean University Simón Bolivar in 2007 and 2008 for scholars from the Andean region, Brazil, Canada, etc., the decision was made that the Andean Commission on Health Determinants would form a Health and Environment Observatory. Its objectives include consolidating a community of national and international practice on health, the environment and society, and encouraging critical analysis and monitoring

[44] Universal access to integral health; total coverage of health infrastructure by the State; no to privatisation of health services; increase in public spending in health and education; prevention programmes, particularly of cancer and sexually transmitted illnesses; food security and social security for all; programmes and mechanisms to ensure social participation in decision-making; development of a national pharmaceutical industry and generic drugs; including traditional medicine and indigenous knowledge in the health system; protection for occupational health, including programmes for the handicapped (Jürgen Kraus report 2010).

of health and environmental issues in the region. The Observatory supports initiatives, research and historical perspectives and innovatory thinking on health, with community and international outreach. Innovative methodological approaches are also being created and validated, such as *'Ñawi'* a digital form of testimony for communication and scientific research. (www.uasb.edu.ec/saludyambiente)

- **Masters Degree in Health with a focus on Ecosystems**, University of Cuenca. The MA seeks ways to foment a harmonious relationship between human beings and nature. It is based on a transdisciplinary, intercultural and equitable approach, promoting community participation in analysing and finding solutions to problems they face with emphasis on social and ecological determinants. National and international scientific exchange promotes South-South and North-South cooperation. The MA seeks to "form professionals with knowledge, attitudes, applied abilities and technical skills which contribute to 'buen vivir' (quality of life) and to efficiently reducing environmental problems that affect the health and wellbeing of people and the environment. http://maestriasaludecosistema.com/index.php/sede-cuenca.html

- **South Environmental Clinic:** The University of Cuenca's Medical Science Faculty, the Andean University Simón Bolivar and Acción Ecológica have launched a new initiative creating '*environmental clinics*'. These are set up in communities affected by socio-environmental conflicts, and include participatory research, public denunciations and direct attention to community and actions enhancing sound ecological and environmental practices. The initiative seeks to overcome the divide between academia and community, with emphasis on the latter's needs and search for change. Through participatory research-action information is gathered and appropriate solutions are sought. The clinics work on occupational health, petrol metabolism and health, methodology to form health promoters, agro-toxics and the green revolution and the recuperating 'Alegremia'[45], and using creative techniques such as puppets and theatre.

- **Intercultural health:** an important impact of II PHA was to get indigenous conceptions of health, healing and traditional medicine on board at the University of Cuenca for the first time. Significant steps forward have been made since then. These include the formation of 60 community health promoters (in their majority women) on weekends by faculty professors. Through the Intercultural Coordination for People's Health, professionals also work with the communities and promoters through generating discussion around indigenous knowledge and intercultural health practices, systematising and validating community experience, and finding solutions to problems faced by the communities. Strong emphasis is placed on the exercise of rights and participation in local and public policy.

- **Inclusion of women and marginalised groups**

The movement, according to some, is male-dominated; one male university professor states "*there is almost equal participation numerically, in qualitative terms as well though this is not always valued, and women's contributions need to be made more visible. Space needs to be opened for women in decision-making; it's always a struggle... In communities it's far worse, the women are 'mingueras' (i.e. they participate in collective activities as service to their communities), they participate in strikes, but never in decision-making*". While some women have become recognised regional and national health movement leaders, they need to combine this with their other multiple roles as mothers and heads of household, members of women's movements, unions and political parties. This leads to

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[45] "*Alegremia is a term coined in Argentina (Julio Monsalvo et al) to indicate the 'joy in the blood', a state of well-being that can only be reached when people have love, food, water, air, shelter and art in our lives... It encompasses a holistic and dynamic understanding of health.*"

dispersion, overstretching and difficult personal options: "*There are very few women who are mothers-wives that can participate; many of us have to give up marriage to become a leader*". If it is difficult for professional and urban women, it is even more difficult for women in the communities: "*it is impossible for peasant women to travel; who can they leave their children and husband with? There's a whole set of obstacles that aren't visible, so women delegate to the men... Women's representation is much greater in urban areas... But in local struggles, women are the most resolute and take the most risks. Though the visible leader is a man, women are in everything, they're path-breakers; and they also cook (in the community events)*". Indigenous and peasant women often play a key role in environmental conflicts, in the front lines of the protests and facing the police.

While women's needs and interests do not figure on MSP-Ecuador's demands (although these include specific measures for indigenous, handicapped and the elderly, see footnote 2), several men stand out for their gender sensitivity: women -particularly indigenous- figure highly in Equipo Comunicándonos materials, some of which are devoted entirely to women (see *Warmi* http://www.archive.org/details/WARMI_356), Dr. Jaime Breilh has numerous publications about gender, and women comprise the majority of promoters being formed by Drs. Freire and Parra. Indigenous people, knowledge and health are high up in MSP priorities, and constitute the majority of communities affected by mining projects and dams. Afro-descendents receive less attention, though this is also due to geographical considerations. Children are a significant priority, and the elderly figure high. No mention was made of work with lesbians, gays and transgenders.

Relations with PHM Globally

While PHM-Ecuador has close ties, connections and frequent joint activities with the PHM in Latin America, identification with PHM globally is more tenuous. An Ecuadorian participates in CoCo, and South America is also represented on the Steering Council. However, a grievance echoed in various interviews is that Latin American priorities figure low if at all on PHM's global agenda. Some expressed grievances which have made them take distance from the PHM: "*I was invited to take part in Global Health Watch. I went to London. I thought the important contributions coming out of Latin America (in theoretical, methodological and political terms where we are very strong) would be recognised. But people on the northern left rendered us invisible... All the proposals I made fell on deaf ears. We were treated in a way that was out of place*". A report on Sports and Health was rejected by GHW leadership on the grounds it was 'too left'. Several key figures are beginning to doubt the benefits of continuing in PHM if their participation continues to devalued and feels like tokenism.

A point of particular contention is that such great priority has been given to WHO advocacy. The debate has to do with the previous experience of ALAMES (the Latin American Association of Social Medicine). ALAMES spearheaded social critique and bottom-up approaches to health in the seventies and eighties. "*But then neo-liberalism arrived and ALAMES became bureaucratic, it became an appendix of PAHO... I publicly resigned... I wasn't a co-founder of ALAMES to become dependent on PAHO*". The critique is not that PHM should not do advocacy work around the WHO; rather, it is that this should take such priority over and above other pressing needs and issues. Another interviewee complained that although information has been sent, PHM globally has done nothing to promote the upcoming *Continental Meeting on Water and the Pachamama*, given the importance and magnitude of this event (see above). Importantly, a couple of individual activists talked highly of their ongoing contacts with specific members of PHM globally, and one spoke warmly of previous ties with PHM-US. However, the majority of people interviewed have either no contact whatsoever with PHM globally (despite the II PHA and IPHU in Cuenca!) or feel deprecated. This is a cause for concern. Language is clearly a barrier, though Spanish is amongst the most widely spoken languages in the world.

Opportunities, Risks and Challenges

- Interesting lessons emerge from the experience in Ecuador which could nurture the PHM as a whole: a) the consistent bringing together of integral health, environment, grassroots participation and culture, or local community identity and practices in the search for social and environmental justice and the exercise of rights. b) Methods are innovatory and holistic, including participatory research, promoter and capacity-building, advocacy and social mobilising. Great emphasis is placed on communication (particularly video, audios, photos, websites and written documents), and on fomenting human dignity and creating joy, fun and happiness in a context of deepening inequality, exclusion, and damage to the environment.

- In particular, much can be learned from Ecuador and other Latin American countries' innovative work on **health and environment**, which could be adopted by other regions, and built on by the global movement.

- There is a shared feeling in Ecuador that the movement cannot continue to be so unstructured and undefined, as this contributes to ambiguity and inertias. What course the movement will take –increasing ties with PHM or taking distance- will depend importantly on whether PHM globally takes on board priorities and initiatives coming from Ecuador and Latin America in general. PHM needs to find a way of respecting country and movement autonomy, at the same time as enhancing coordination, joint initiatives and an across-the-board identity, feeling of belonging and joint struggle. Several interviews pointed to decentralisation as the best solution (with regional offices in each continent and subcontinent). One person interviewed hoped that PHM could adopt the Mexican National Indigenous Congress (CNI) and Zapatista model which works as: "*a **network** when they are apart and an **assembly** when they get together*".

Appendix 9

People's Health Movement, Srilanka (PHMSL): Right to health in the context of global politics and war /conflict

Evolution of the Peoples' Health Movement Sri Lanka (PHMSL)

The Peoples' Health Movement in Sri Lanka (PHMSL) or *Janata Sowkya Sansadeya*, the Sinhala term for PHM emerged in the year 2001 with a Srilanka Health Assembly, following the People's Health Assembly (PHA) in Savar, Dhaka in December 2000. The Srilankan group that attended the PHA comprised 39 persons from different organisations. The group included representatives from organisations, networks, the Ministry of Health[46], etc.
After the PHA, Srilanka decided to adopt the Charter. It was translated into Sinhala and circulated widely for endorsements. The endorsees of the charter became part of the PHMSL. Membership is open to anyone – organisations as well as individuals, who endorse the charter.

The initial group unanimously decided that Dr. Vinya Ariyaratne of Sarvodaya should be the coordinator of the PHMSL. Sarvodaya had been active prior to the PHA in mobilising for the assembly and agreed to contribute time to the PHM. The choice of Dr Vinya as coordinator was based on his credibility and Sarvodaya's relationship and influence with the government and the resources at its disposal that could facilitate coordination. The PHM became a full time activity of the community health unit of Sarvodaya. There has been no separate fund raising for PHM. Sarvodaya has also been able to provide space and hospitality for the PHM monthly meetings.

Many of the respondents feel that the credibility of the organisation – Sarvodaya, its proximity and influence with the Government, the infrastructure and resources at its disposal are some of the key reasons for the development of PHMSL.

PHMSL has from the beginning and continues to have the same coordinator (Dr. Vinya Ariyaratne) and convenor (Mr Sirimal Peiris). The roles of the convenor and coordinator seemingly overlap; it would be useful to have further clarity about the respective roles.
Currently, the convenor plays a very active role in coordination of the PHMSL. He communicates with the PHM members, facilitates resource persons for the continuing sessions for IPHU participants and he was the person who coordinated the evaluation visits. He had all the archival material, presentations, plans, etc., for the PHM. Some respondents were concerned about the role that the convenor plays currently and wondered what would happen to PHM in the absence of such commitment and active coordination. This was clearly stated by the coordinator in the run up to the review, as "my colleague who is coordinating all PHM work in Srilanka ……".

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[46] "Sarvodaya had a good relationship with the health ministry and they were able to convince that it was important for them also to be part of this".

Several individuals and organisations had been working on issues of health, conflict, access to medicines, etc. in Srilanka as part of networks and coalitions in the region even prior to the PHA in 2000. For instance, workshops by ACHAN which had been attended by some persons who were now part of PHM. For instance, a workshop on globalisation had been organised in Srilanka for which the resource persons were from countries in the Asian region and now part of PHM.
Some of the respondents shared that after 2000, their work started in a more systematic way. For example, organisations working on the issue of drugs were able to consolidate their work – they became more involved in the drug policy, examining prescription practices, generic, traditional and branded drugs.

Structure
The PHMSL is perceived as movement as well as a network by some and as a network whose ultimate goal is the movement by others. As a network it has a structure, a letterhead, etc. Most of the decisions are taken during the monthly meetings and issues that need to be prioritized are flagged. Most decisions are taken at the meetings every month by whoever is there. On an average, about 20-25 persons / organizations attend the monthly meetings. The convenor takes the lead in presenting issues, facilitating discussions and bringing new organizations into the PHM. Decisions are made collectively by the group.

Recently, about 2-3 years ago a process of decentralisation was begun to facilitate larger participation in the PHM. Presently there are PHMSL groups in 3 districts – Kandy, Badulla and Mondragale. The goal is to have PHM groups in all the 9 provinces of Srilanka.

Profile of organisations associated with the PHMSL
Currently 53 organisations are part of the PHMSL. About 10 groups / organisations were part of PHMSL in the beginning; individuals and organisations kept joining. These include political left parties, faith based organisations, trade unions, community based organisations, health educators, women's organisations, etc. working on health issues, on access to drugs, women's health and livelihoods, rights of the marginalised communities (Telugu people), indigenous health systems, food security, sex workers' and PLHA's rights, with people and workers in plantation areas, on issues of conflict and peace building and others. The identity of the PHM is also formed through the work that is done by the member organisations. Efforts are ongoing to mobilise organisations and well as individuals to be part of the PHMSL.

Mobilising participation in the PHM

Mobilisation towards participation in the PHM has happened mostly by word of mouth and based on organisations' interests. No specific process has been initiated to mobilise organisations and people. Many of the organisations have felt the need to be part of the PHM as it lends strength and support to issues. PHM has gained recognition in Srilanka and is approached by diverse groups and individuals – for example, the government printers union have joined the PHM as their occupational health problems were not being recognised.

PHMSL Activities / Campaign areas
Right to health and health care, Peace building, access to medicines, campaign against GM foods, strengthening of people's knowledge of medicine and healing, HIV and AIDS, etc. are some areas for campaigns and advocacy identified by the PHM SL. The priorities are discussed and set during the monthly meetings in Colombo. The following are some of the activities initiated or being planned by the PHMSL:

- Building awareness of organisations
- Campaign for recognition of health as a right – provision of a constitutional mandate.
  Maintenance of a data base and information centre about organisations
- Campaigning for health rights – protests, dissemination of health materials
- Empowering health activists and liaising with district level processes to raise ground issues at the national level
- Launch a newsletter on PHM, website
- Develop a citizen report (Alternative Report) on the health situation in Srilanka
- Establishment of a people's commission on health issues
- Conduct necessary studies and research
- IPHU
- Promotion of indigenous / people's health systems

The PHM SL has focused on advancing health rights, been actively involved in advocacy regarding the Drug Policy. During 2002, there was a ceasefire in the war in Srilanka and PHMSL was able to lobby for constitutional reforms. Although health care was free, there was no constitutional guarantee for health. The campaign for right to health to become a constitutional guarantee has been the focus of the PHMSL.

Capacity building for PHM members is through seminars and workshops organised by PHM members on different issues. More recently the IPHU has also provided an important opportunity for this. Following the IPHU, The Srilankan IPHU participants (about 50 percent) meet every two months. This is a process of ongoing capacity building that has been initiated. Resource persons on diverse issues are invited to present at these sessions.

The IPHU in Srilanka comprised 60 persons, of which 21 were Srilankans. They were selected from among the organizations that were part of the PHM. The follow up sessions are coordinated by one or two participants. So far, 3 such follow up sessions had been conducted. Resource persons are identified by the participants; the convenor also helps in this process.

Publications
PHM SL has published booklets and leaflets as and when necessary; has developed posters to campaign for health rights and to create public awareness, strongly campaigned to include health rights in the Sri Lanka Constitution. A newsletter has been developed providing an overview of these and more achievements.

The letter head has the names of all the organizations and individuals who are part of PHMSL. There did not seem to be a publication protocol, regarding use of PHM logos, names on publications, etc. The newsletter is available online and states "PHM Srilanka". It does not have the names of individuals / organisations.

Communication within PHMSL and between PHMSL and regional /global PHM
The PHM SL communication is mostly initiated and coordinated by the Convenor and email communication seems more a tool for coordination between members than a discussion forum.
The decentralised functioning has also facilitated focus on issues / advocacy at the district and provincial authorities. For example, the PHMSL in Kandy focuses on the issues of health and rights in the plantation areas. Thus there has been an effort to incorporate local issues in the national PHM, while mobilising around national concerns in the provinces and districts.

The IPHU was perceived as a milestone in communication between PHMSL and global PHM since the IPHU in Srilanka, in 2010. Some of the PHMSL members felt that the communication had improved since as they had met and interacted with some of the people who are active at the global level. Otherwise the links between the PHM SL coordinator / convenor and the global secretariat or the regional secretariat was minimal.

Regional PHM
Organizations and individuals expressed a keen interest in regional level processes. At present such processes were either non existent or they were unaware of any regional level activities. Regional processes, it was felt, would bring together PHM given a particular context and commonalities; facilitate advocacy at the regional level and also provide opportunity for learning and sharing experiences in the region. Some respondents mentioned an annual regional meeting / assembly as an important step to activate regional level processes.
There is interest in knowing about global issues, connecting with global initiatives and strategies. On the other hand, the PHM being a global movement, there is an expectation for global visibility for issues that are local / specific to Srilanka. For example, the health situation of people in plantation areas of Srilanka who lead extremely marginalized lives – and a majority are Tamils. The need for transparency and strengthening communication and need for better linkages was expressed by several respondents.

Inclusion: gender and other marginalized groups / issues
Nothing specific to gender by way of initiatives has been conducted so far. While organisations are engaged in gender related campaigns / analysis, and the PHM recognizes some of this, there is a long way to go. (When asked about the Gender Committee, most of them had not heard about it.)

There are several women leaders of organizations, who are active in the PHM. However, some of those who spoke expressed that their understanding of gendered spaces in PHM would mean the participation of "ordinary people (women)" in the

PHM's decisions and planning. Some believed that decisions were made by a few and was not through a collective process - not specifically about a 'men' versus 'women' situation but a 'few' versus 'many'.

PHM has provided a platform for marginalized communities and issues, but this needs to be strengthened and institutionalized rather than based on "opportunities". The PHMSL had attempted to visibilise the issues of the marginalized – for instance, sex workers associated with a PHM organisation were invited to present at the IPHU. However, they do not participate in monthly meetings yet. It is usually attended by representatives of organisation that works with sex workers. Some respondents expressed their hope that in the future, PHM will be able to mobilize participation from marginalized communities by providing the necessary spaces for them.

One respondent felt that the PHM like the Trade Unions was still "only about men and not about women".

Funding

The PHMSL is not funded. Specific activities or events of the PHM like the IPHU may be funded but ongoing initiatives depend on the voluntarism of PHM members and their contributions. This was perceived extremely positively by most respondents. However, in the present context with financial support for NGOs becoming increasingly difficult in Srilanka, respondents raised some issues and concerns in the absence of funding. While the lack of funding for PHM was not seen as an issue, the dwindling resources of organisations was seen to have an impact on the functioning of the PHMSL – on mobilisation, participation of community based organisations as well as people who might want to be part of the PHM.

> *The concept of voluntarism is important. This is also a challenge because of the voluntary nature of the PHM. It is sometimes difficult for organisations to contribute, time resources – human and financial. This way it is voluntary and stronger. For some activities / events we can get money, which will be useful. But it is better not to have funds for daily activities.*

Some key achievements

- PHMSL has played a critical role in bringing together individuals and organisations working on health issues and in bringing marginalised issues to the forefront.

- PHMSL has managed to mobilise and bring together 53 organisations and networks and has strengthened linkages between them.

- Mobilisation of support from some policy makers who are considered to be 'part of the PHM'. However, some PHM members are also critical of these policy makers and feel that they have not done enough and that their being in the government might also be the determining factor for PHM's stand / strategies on many issues.

- It is seen as providing support and solidarity and the collective nature of the PHM is perceived as important in the current political context where there is increasing targeting of individuals. In such a situation the PHMSL has the potential to counter the situation and sustain its initiatives and campaigns.

Challenges

- The political scenario is extremely anti NGOs and people's movements and there are multiple issues that have emerged.

- While a number of the persons interviewed felt that awareness about the PHMSL has increased in Srilanka, PHMSL still does not have a strong public profile. PHMSL has yet to reach out to the people as well as to organisations and networks that are working in remote areas.

- PHMSL is also at times muted / postured in its public criticism of health policies, etc. This may be a consequence of the organisation in leadership as well as the close association of political leaders with the PHM.

- Although many organisations are part of the PHMSL only a few are active; future strategies to enable active participation is critical. PHMSL's active coordination was perceived as dependent on a few individuals, difficult to sustain in the long run.

- PHMSL needs to expand its lens and work on gender, equity issues – at the organisational as well as at the level of campaigns and issues is perceived as an urgent step.

- Although individual organisations have been involved in peace building, PHMSL has not positioned itself strongly about the conflict situation / war in Srilanka. As PHM has not done much work on conflict – more leadership / lead is required on this front.

Appendix 10

People's Health Movement, India: Jan Swasthya Abhiyan (JSA)

Evolution of the JSA

"India witnessed the largest mobilisation, spread across almost 30,000 villages. More than 2000 organizations participated in this countrywide mobilization in about 300 districts in 20 states. 18 National Networks jointly led the campaign. This was the first time the country witnessed the coming together of so many diverse organizations and movements. Based on village and primary health center level enquiries, many districts drew up local health priorities, which were fed, into district convention and state conventions.

The final culmination of this nationwide process was the National Health Assembly (NHA-I) held in Kolkata on 1st December 2000. More than 2300 delegates from all parts of the country traveled to Kolkata for the National Health Assembly in five People's Health Trains. The National Health Assembly declared the major goals of the Indian People's Health Movement and demarcated the specific issues on which the People's Health Movement in India would concentrate. It adopted a 20-point charter known as the Indian Peoples' Health Charter, outlining a critical analysis of the Indian health scenario in the context of globalization. This charter provides a statement of the shared understanding and goals that unite all the organizations working as part of this network of networks. The assembly culminated in a 30,000 strong rally followed by a public meeting".[47]

> *The group that came together prior to the PHA, was broad – they were organizations and networks from across the political spectrum. That health for all had not come to India perhaps motivated them along with the realization that the larger global – political scenario regardless of what sector or work one was doing was impacted by some commonalities. There was probably a recognition of multiple issues, reflected in JSA's charter, and discovering that health is all of these.*

The national networks and organizations that had come together to organize the National Health Assembly, at the time only focused on the assembly. They then decided to continue and develop this movement in the form of the Jan Swasthya Abhiyan (the Indian chapter of the People's Health Movement).

Some of the states within India had a long history of people's struggles and movements around social issues. This, according to some, also determined / facilitated the growth and functioning of the JSA in some states.

Jan Swasthya Abhiyan: Perspective and Objectives

The Jan Swasthya Abhiyan believes that despite medical advances and increasing average life expectancy, there is disturbing evidence of rising disparities in health status among people worldwide. Enduring poverty with all its facets and in addition, resurgence of communicable diseases including the HIV/AIDS epidemic, and weakening of public health systems is leading to reversal of previous health gains. This development is associated with widening gaps in income and shrinking access to social services, as well as persistent racial and gender imbalances. Traditional systems of knowledge and health are under threat.

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The JSA is of the opinion that these trends are to a large extent the result of the inequitable structure of the world economy, which has been further skewed by structural adjustment policies, the persistent indebtedness of the South, unfair world trade arrangements and uncontrolled financial speculation – all part of the rapid movement towards inequitable globalisation. In many countries, these problems are compounded by lack of coordination between governments and international agencies, and stagnant or declining public health budgets. Within the health sector, failure to implement primary health care policies as originally conceived has significantly aggravated the global health crisis. These deficiencies include:

- A retreat from the goal of comprehensive national health and drug polices as part of overall social policy.
- A lack of insight into the inter-sectoral nature of health problems and the failure to make health a priority in all sectors of society.
- A failure to promote participation and genuine involvement of communities in their own health development.
- Reduced state responsibility at all levels as a consequence of widespread and usually inequitable policies of privatisation of health services.
- A narrow, top-down, technology-oriented view of health and increasingly viewing health care as a commodity rather than as a human right.

The major objectives of the Jan Swasthya Abhiyan are as below:

1. The Jan Swasthya Abhiyan aims to draw public attention to the adverse impact of the policies of iniquitous globalisation on the health of Indian people, especially on the health of the poor.
2. The Jan Swasthya Abhiyan aims to focus public attention on the passing of the year 2000 without the fulfillment of the 'Health for All by 2000 A.D.' pledge. The JSA seeks a renewal of this commitment, with the slogan 'Health for All - Now!'. The JSA locates the campaign to achieve this in the campaign to establish the Right to Health and Health Care as basic human rights. The JSA also believes that Health and equitable development need to be reestablished as priorities in local, national, international policy-making, with Primary Health Care as a major strategy for achieving these priorities.
3. The thrust for privatisation and retreat of the state with poor regulatory mechanisms has exacerbated the trends to commercialise medical care. Irrational, unethical and exploitative medical practices are flourishing and growing. The Jan Swasthya Abhiyan expresses the need to confront such commercialisation, while establishing minimum standards and rational treatment guidelines for health care.
4. Top down, bureaucratic, fragmented techno-centric approaches to health care lead to considerable wastage of scarce resources and fail to impact significantly on the health situation. The Jan Swasthya Abhiyan feels that there is an urgent need to promote decentralisation of health care and build up integrated, comprehensive and participatory approaches to health care that places "Peoples Health in Peoples Hands".
5. The Jan Swasthya Abhiyan seeks to network with all those interested in promoting peoples' health. It seeks to initiate and promote a wide variety of people's initiatives that would help the poor and the marginalised to organise and access better health care, while contributing to building long-term and sustainable solutions to health problems. [48]

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Structure

The JSA national organizers group comprises of a national convenor and eight joint convenors. The joint convenors were earlier from specific geographical regions and expected to lead and coordinate mobilization and initiatives in their respective regions. Each state has its own coordination group and structure. Some states have further decentralized structures - created for improved co-coordination and for better outreach to different regions within the state, towards focus / prioritization of issues, coordination, mobilization. However, the state level JSA in many states is inactive and requires rejuvenation. Further, the need to expand JSA within the states – mobilize participation of many more organisations and networks is critical.

The national organizers group includes women and men – currently 3 and 5 (six men including the national convenor) respectively.
Some of the roles of the convenors' group is to facilitate democratic processes, to follow up, build consensus and conflict resolution.

Lack of rotation of convenors was perceived as a drawback and prevented wider participation and new leadership. The structure of the NCC and the processes for membership at the state level need to be reviewed.

> *In JSA we definitely need a rotational process. For e.g., the convenor has been the same for 10 years. The secretariat has been rotating but there are issues of lack of coordination. …. now it is completely dormant.*

Leadership and governance were perceived as critical elements for JSA, especially at present where both are considered to be weak or inactive. This situation was not perceived as because of the lack of potential leaders or their willingness to play this role, rather as a result of no concerted action on this front. One respondent felt that this was, in general, unwilling to reflect on organizational issues.

The JSA's National Coordination Committee (NCC) consists of representatives of member organizations responsible for planning and coordination. At present the JSA NCC comprises 22 national level organizations and networks.

The discussions highlighted concerns about the present structure at the national level; does it lend itself to expansion, growth? There was lack of clarity about the rigidity of the 22 organisations /networks. State level PHM activists expressed that such a structure excludes organisations that are active in the people's health movement at the state level. Networks and organisations that are part of the 22 NCC members are also not necessarily active at the state level. The national structure therefore is not a whole / complete reflected of the mobilization of organisations and issues in different states of the country.
What if the groups that are actually active want to become part of the PHM, gain recognition – is there a process for formal recognition? Why are some organisations / networks "recognized" and others not. Should states have their state level letterheads or some such things that can provide visibility and formal recognition.

Coordination within JSA

Coordination at the national level is carried out by a national secretariat, housed in an organisation, led by a national coordinator. Similarly each state also has a coordinator. The responsibility of national and state level coordination is rotated. The national and state

coordinators and secretariats play a crucial role in flagging issues, facilitating Interlinkages between PHM organisations/activists, dissemination of information, mobilization, coordinate meetings, etc.

The need to improve coordination within the state and also across states, as well as at the national level in India, was expressed by nearly by all those who were interviewed. At present the governance, coordination structures were far from active, was a concern expressed by many. Coordination of JSA had seen some rough times in the past, but the present time was perceived as the most inactive period for JSA.

Given the spread of the country and in keeping with the goal of expansion, wider mobilization and responding to the myriad health issues, a strong national / central coordination was seen as extremely important.

A few respondents said that national level coordination, from past experience, had clearly shown the need for dedicated persons involved in coordination.

> *JSA has huge potential. It is a group of peers not "one person led". In that way, it is different from other networks. It has also made the second line of leadership possible. There have really not been any issues of keeping anyone down. It has promoted leadership, skills (albeit in a limited way). It is a growing movement.*

All respondents reinforced the significance of the people's health movement at the national, regional and global levels particularly in the current global eco- political context. Therefore the need for revival of the JSA, which as one activist described is "paralysed but not dead" and a more coordinated functioning by the PHM were urgently required. There is also need for the national coordination group to play the role of conflict resolution between organisations and networks that may impact the working of the JSA in a state.

JSA identity: Movement or Network

The perceptions about PHM's identity – whether a movement or network - were varied. While some respondents were very clear about the PHM being a network / a "network of networks", one activist described it as a "campaign for a movement", and some others felt that it was a network with the goal towards building a movement for people's health.

A disjunct and paradox exists in the PHM. The nomenclature and understanding of a people's health movement rests on people's involvement / movement for health, to achieve their health rights. However, responses highlighted the implications of the understanding of the identity. For example, the nature of engagement as a network and as a movement, according to some, would differ. Governance, decision making structures of JSA, as they exist, are more akin to a network than a movement. The identity would also have implications for funding – whether or not to receive funds, to what extent, for what activities / aspects should funding be sourced, etc. As one activist expressed,

> *I personally feel that it is not a movement right now. They (some JSA activists) say that it is a network of networks and hence does not confront (the state). .....confrontation is not a PHM method. Voices against are not acceptable? But a movement is not only " health is political" but to " politically see health". There is no political strategy.*

Another reason for not perceiving the JSA as movement was the limited involvement of grassroots people, organisations at the local level.

There is limited reflection of lack of mobilization at the grassroots even at the global level. Sustained multi-centric mobilisation, especially at the grassroots level is missing. The steering committee members may also in some ways be a reflection of this – not rooted in people's health movements.

Profile of organisations associated with JSA

The profile of organizations associated with JSA is diverse. A complete /compiled list of all organizations, who are part of JSA does not exist yet. JSA comprises people's movements, indigenous / adivasi movements to academic institutions, women's organizations, organizations working on disability rights, mental health, food security, etc. across diverse political ideologies. However, not all organizations working on these issues have a national presence and vice versa – i.e., not all organizations at the national level are active in the states. This has raised some concerns about "the need for recognition of organisations who are part of JSA". There is need to put in place some mechanism for this at the state and national levels.

Groups want to be part of JSA. How do they become part of it? How will a new adivasi group become part of it. There is no clarity about this. Do groups have to approach the governance at the national level or the coordination unit or group at the state level?
Some of the national networks that are part of JSA are not necessarily part of the state JSA. Here they were dysfunctional but we cannot remove them from the letterhead, for example, and include other groups. How do groups that are actually active become part of it; gain recognition?

Mobilising participation in JSA

Mobilising continues to be a major challenge for the JSA. The lack of mobilization is seen as one of the biggest gaps within JSA. While this is well recognized, proactive action to address this need to be urgently initiated. Mobilisation has to be multipronged. It has to extend to newer geographical areas / states where JSA is not active presently; within areas and states where JSA has a presence and is active, there is need to reach out to others – organisations and groups working on health and other issues. There is particular need to mobilize organisations and networks working with dalits, adivasis, LGBTQI..., working on issues of disability and mental health. It is also important to involve organisations that are working on health issues but are currently not part of JSA.

There is a very big gap in community mobilization. The second National Health Assembly that took place in March 2007 provided a great opportunity for expansion. It witnessed a wide mobilization of groups organisations and networks working with the marginalized and on diverse health issues. However, we just let it slide and did not follow up sufficiently.

With regard to mobilization, one of the greatest challenges is to sustain the active involvement of groups at the state and national levels. Strategies need to be deliberated, sharing of positive experiences in this regard from the states and even other countries where PHM is active would be useful. Strengthening a collective, common understanding of PHM / JSA's understanding of health may be the first step in this direction.

There are differences in groups – e.g. disability or mental health want to focus on their issues, not perceiving that unless primary health care is available to all, these will also not get resolved.
Another drawback is – for example, sexual minority groups – only when someone gets affected then they raise the issue or are actively involved. But they should be part of the movement even otherwise. It is a challenge to sustain collective effort.

While not all organisations and groups may be active in all campaigns and initiatives by the JSA, it is a challenge to expand their engagement so that 'other' issues and campaigns (issues that they may not be engaged with directly) also gain their support and solidarity.

JSA Activities / Campaign areas

Areas of Interest and Themes

Jan Swasthya Abhiyan has within its wide range of members, a large number of resource persons, and activities in a number of thematic areas. The important areas are listed below:

- Policy level interventions for Right to Health and Health Care
- Primary Health Care and health systems that can provide access to health care services for the poor and the marginalised
- Community Health Worker Programmes and Community Based Monitoring of Health services
- Women's Health issues and Reproductive health rights
- Child Health and Malnutrition
- Right to Food and investigation of hunger related deaths
- Violence & Women's Health
- Sex determination and sex selective abortions
- WTO, Intellectual property rights, patents and Drug policy
- Medical Professional Reform and Regulation of medical practice
- Privatisation of health services and the commercialisation of health care
- Health care in conflict situations
- Indigenous Medicine and Folk healing traditions
- Rational Drugs and Diagnostics
- Drinking Water, Sanitation, Environment & Health
- Health among Displaced people, Adivasis and other marginalized sections
- Population control programme and issues of Contraceptive choice
- Trends in Medical and Vaccine Research
- Control of Communicable Disease
- Mental Health issues
- Human Resource Development for Health Care
- Tobacco Control for better health

Major Co-ordinated Campaigns of the JSA

The participating organisations and networks in the JSA have their own independent activities. In addition, the JSA co-ordinates national or regional campaigns/activities that involve all or a major section of its constituents. Some of the major campaigns initiated and co-ordinated by the JSA are as follows:

People's Rural Health Watch (PRHW): The idea of a People's Rural Health Watch was conceived of by JSA following its Right to Healthcare Campaign, and after the launch of the NRHM. From the public hearings during the Right to Healthcare Campaign, it became evident that the problems were more systemic rather than simply isolated cases of denial of healthcare by some health functionaries. *Given the objectives of the NRHM to improve rural health services, PRHW was viewed as a way of looking at the performance of the rural public health system, and of analyzing and assessing the issues arising out of its implementation. It would be an activity to document and assess what were the areas that were getting more attention in the implementation process, whether or not people were getting better health services with the introduction and implementation of NRHM, and provide some feedback for improvement.*

This was to be done by collecting primary information through periodic surveys, as well as by looking at relevant policy documents, and preparing reports based on all this information. These reports were to be widely disseminated and discussed, and would also be the basis for mobilization and action at the local level. The information collected was to be also used to support monitoring of health services by civil society organizations, and to watch for and check possible negative developments in the context of the mission.

The PRHW activity was planned as a two-year activity, between January 2006-2008. The final Report of this activity is now ready and brings together and analyses the information collected over 2006-2008, from surveys carried out in some high-focus states and from policy documents and published reports. The Report is based on data received from MP, UP, Bihar, Rajasthan, Jharkhand and Chhattisgarh.

Right to Health Care Campaign: A nationwide campaign by Jan Swasthya Abhiyan to establish the Right to Health Care as a basic human right for every citizen in India. As part of this campaign Public Hearing on Denial of Health Care have been organised all over India in collaboration with the National Human Rights Commission.

Campaign against Sex Selective Abortions: In response to the Public Interest Litigation regarding Pre Natal Diagnostic Tests and Sex Selective Abortions filed in Supreme Court, JSA initiated a campaign related to constitution of appropriate authorities, registration of ultrasound centers, ban on advertisements, displaying posters in clinics and the issue of son preference. This campaign was taken up intensively in a number of states especially in Tamil Nadu, Haryana and Himachal Pradesh in the second half of 2001.

Hunger Watch: Jan Swasthya Abhiyan has set up a 'Hunger Watch' group consisting of public health and nutrition experts to provide assistance to the Right to Food Campaign. A JSA 'Hunger Watch' group has prepared a protocol to investigate cases of hunger-related or starvation deaths.

Involvement in the Right to Food Campaign: In several states, surveys have been conducted by JSA constituents on the status of mid-day meal and other schemes. In several states, a convention on 'Right to food - Right to health' have been organised. A resource material package in the form of a book "If even one person goes hungry...." was brought out by Tamil Nadu Science Forum and Bharat Gyan Vigyan Samiti for the Right to Food campaign and it has served to inform the public and keep the issue alive. There is a growing focus on 'Children's Right to Food' and Jan Swasthya Abhiyan has played a key role in the development of this campaign and issue within the overall campaign for the Right to Food.

Civil Society Facilitation in the Asian Region for the Commission on Social Determinants of Health: JSA has been identified as one of the two organisations in the Asian regions to facilitate civil society participation in the Commission on Social Determinants of Health, constituted by the WHO. Towards this end JSA has helped convened meetings in 10 countries of the region. JSA is in the process of facilitating Civil Society inputs into the Commission's final report.

National Health Assembly II: In March 2007 the JSA oprganised a three day National Health Assembly in Bhopal, that brought together over 400 organisations and over 2000 participants from across the country. For three days the participants discussed and debated on several thematic areas. The Assembly also saw the participation of about a hundred foreign delegates, who participated in a special session that focused on global concerns on Health. The Assembly also discussed the thrust of future activities for JSA, which are detailed later.

Interventions by the JSA in major issues related to Public Health

In addition to the major campaigns described above, JSA has intervened in several national policy issues and processes. Some of the key ones are listed below:

National Rural Health Mission: The National Rural Health Mission aims to fulfill the United Progressive Government's commitment to meet people's aspirations for better health and access to health care. The JSA is, however, of the opinion that the Mission must move beyond populist policy rhetoric and become part of a bold paradigm shift, from providing services through top down planning to building capacity and empowering communities to manage their own health care needs. The JSA is engaged in impacting on the development of the Mission's perspective and plan of action through dialogues with policy makers, participation in the Mission's Task Forces, and mobilisation of its constituents.

TRIPS and the Indian Patent Amendment Act: The TRIPS agreement required India to change to a Product Patent regime in the area of pharmaceuticals and food, from the earlier system provided in the Amendment of the Indian Patents Act of 1970 which did not provide for Product Patents in these areas. Such a move has many negative implications on people's ability to access essential medicines. The JSA has been an active partner in the campaign to pressure the government to make full use of the safeguards available in the TRIPS agreement to safeguard Public Health.

Initiatives related to Drug Policy: The JSA has been active in pursuing the development of a National Pharmaceutical Policy that addresses the critical issue of universal access to essential medicines and of national self-reliance. The National Policy on Pharmaceuticals was discussed when it was in the draft stage and a JSA critique was evolved which was widely shared. JSA participated in a public campaign concerning the Pharmaceutical Policy, that was initiated by one of its constituent organisations – the Federation of Medical Representatives Association of India (FMRAI). Many states have held discussions regarding an essential drug policy and to build public awareness on the impact of globalisation on the pharmaceutical sector. In a well attended convention on 5th December 2007, the JSA adopted a charter of demands of the Government and also formulated a plain for future activities. Prominent among these is a call issued by JSA to Boycott products manufactured and sold by the Swiss MNC, Novartis, in protest against its continued efforts to stop local production of its vital anti-cancer drug called Gleevec.

Pre-Election Dialogue with Political Parties : Prior to the elections in April 2004, and in May 2009, Jan Swasthya Abhiyan initiated a dialogue with political parties to encourage them to focus on the real concerns of the Indian people especially political initiatives in health care - most important of which was making health a fundamental right and increasing the budgetary allocation for public health. A discussion with the political parties along with the panelists was organised in Delhi followed by a rally demanding "Right to Health Care". Prior to these meetings a pamphlet and policy brief was circulated to the political parties addressing the various issues concerned.

Women's Health

Following are some of the major activities related to Women's Health that the JSA proposes to pursue as part of its activities:

- Campaign to ensure that justice is done for Bhopal survivors, ensure access to various determinants of health – water, food, livelihoods and access to health services and compensation.
- Campaign to abolish coercive population policies – to revoke the 2 child norm.
- Campaigns on issues of mental health, focus on disability (physical and mental), issues and concerns of sexual minorities.
- Campaign against violence against women – violence within home; state violence eg. Gujarat Carnage, including policies programs which violate womens rights (girl children and adolescent girls); or cause / exacerbate violence against women.
- Campaign on women's, girl children and adolescent girls nutrition. This would require long term follow up and monitoring of nutritional status
- Campaign to implement Supreme Court order on sterilisations; ensure compensation in case of failures / violations. Also ensure conditions / quality of care so that failures are prevented. March 3rd every year could be designated for this campaign as the SC order was made on this day.
- Campaign towards ensuring implementation of PCPNDT Act. There is a PCPNDT advisory committee, which JSA should try and be a part of.
- Laws and acts related to women should be monitored and ensure their implementation. e.g. Domestic violence bill.
- Campaign to ensure care for women and prevent violations in institutions including institutions for mental health. Public hearings could be organized to document experiences of women in public institutions, towards advocacy.

Medicines Policy

Following are some of the activities proposed, related to the drug industry and policies relating to the manufacture, sale, prescription and use of medicines:

- Campaign Committees be formed in all States.
- Campaign for revitalisation of the public sector and observe a day when a nationwide call would be given to promote this campaign.
- Deputations to meet state drug controllers for regulation of prices and weeding out of irrational medicines.
- Consider filing a Public Interest Litigation and/or initiate other measures for weeding out of irrational medicines.

- A campaign booklet shall be prepared listing the areas of concern, to take forward the campaign.
- Organise Public hearing on medicine prices and irrational medicines.
- Discussion with the concerned Ministries to be sought for pursuing the above demands.
- Launch a wide campaign against unethical business practices and unethical promotion by drug companies, and follow up with the filing of specific complaints to relevant agencies against such practices.
- Campaign among the medical students and medical practitioners on issues related to rational use of drugs.
- Promote and intensify the Boycott Novartis Campaign among medical professionals till Novartis ceases its challenge against the rejection of its Patent application on Gleevec.

Child Health

JSA shall work with the Right to Food campaign in advocating policy options that address child malnutrition, including, for example, the expansion of the ICDS scheme. Other interventions to be promoted include a critical analysis of policies promoting food fortification with nutrients and micro-nutrients. [49]

Other activities in the recent past also include the IPHU's Health and Equity Course at Bangalore, India organized in association with the People's Health Movement, Jan Swasthya Abhiyan, Community Health Cell (SOCHARA) and Prayas (Rajasthan) on 1-9 September, 2009 at Bangalore.

Publications

Publications by JSA include:

- The People's Charter for Health
- The National Health Assembly Booklets series (7 nos)
  - Booklet 1- Globalisation and Health
  - Booklet 2 – Health System in India
  - Booklet 3 – Women's Health
  - Booklet 4 – Campaign Issues in child health
  - Booklet 5 – New Technologies in Public Health
  - Booklet 6 – HIV AIDS Treatment Access
  - Booklet 7 – Access to Essential Medicines
  - Booklet 8 – (Draft) Towards a people's alternative health plan

Apart from these draft booklets were also developed on social exclusion, issues with the elderly, etc.

- People's Health Manifesto (2009)
- People's Rural Health Watch Report

In addition, JSA has also drafted policy briefs, memorandums, review papers, etc. Most of the publications mentioned here are efforts at the national level, there are also several states who have developed publications, articles, fliers, posters in the local languages. While some of these are uploaded on the JSA website, a comprehensive repository of all the

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materials, especially from the states would be extremely useful and is a recommendation that has emerged from the evaluation process.

Communication within JSA and between JSA and regional /global PHM

Overall, the responses reflected that the communication within JSA was at an "all time low". While ensuring that communication reaches out the maximum number of organisations and networks, wide dissemination of information and maximum involvement has always been challenging, communication was perceived at the national level to be near absent in the past 1-1 ½ years.
Communication among convenors and coordinators, the national coordination (NCC) takes place through emails. It forms the primary mode of regular communication and is limited at the national level to those who are part of the NCC. Apart from this, meetings at the state level as well as at the national level also facilitate communication – planning, review of strategies, campaigns and initiatives.

Regarding global communication, i.e. communication from global PHM to JSA and vice versa was seen as restricted to a very few people. Therefore, most respondents stated that they were not aware of any of the happenings at the global level. Communication about regional or global PHM process are shared at times by some, but there is no systematic / regular feedback by those who are part of global processes and initiatives. This was also expressed in the context of the present evaluation – respondents expressed that there should have been wider / prior communication about the evaluation.

Regional PHM

Almost all respondents claimed ignorance about PHM in the region. Most of them were unaware of who the regional coordinator was as also the regional structures. The need for a stronger regional coordination and regional exchange of information was expressed. A dedicated person for regional coordination was suggested towards based on the Africa experience. Resources for regional coordination were also identified as a need.
India is perceived as a separate region, which most respondents were not aware of. However, those who were aware, felt that India should be part of South Asia, regardless of its size.

> *We need to prioritise funding for movement building. Right now maximum money goes into IPHU. There is very little money for right to health care and other aspects.*

Gender and Marginalised

While gender is mainstreamed in publications, articles, etc., it was felt that gender perspectives continue to be insignificant. At the global level, while some of the initiatives like CSDH addressed gender, at the national and state levels, there is very little engagement with groups, organisations that have a strong gender perspective. JSA has made attempts, for example, the Indian Women's Health Charter was disseminated at the national assembly, but these are ad hoc. A strategy should be developed for engendering perspectives, campaigns, etc. as well as for ensuring inclusion.

> *There may be inclusion of gender / gendered understanding of issues but this needs to be strengthened. For example on the issue of drugs gendered concerns need to be*

highlighted. Discussion on gender within the PHM, needs to grow. It needs to be part of our decision making process.

JSA was perceived as a male domain and "exclusive". *In some ways JSA reproduced the structure of society.*

In JSA, dalit involvement has been limited to health assembly largely. This was also perceived with regard to other marginalisations. Largely the '*dominant paradigm'* was seen to prevail – whether in governance structures, participation, etc.

Funding

The national secretariat of the JSA has received funding in the past. While the process to source funds by the current secretariat was initiated, no funding support has come through so far. Most of the respondents stated that funding was important to coordinate, towards wider mobilization. At the state level, it was not possible to gain information in this regard in the process of the evaluation. In one of the states, the organisation who is coordinating the JSA, had included the costs within their overall organizational proposal / budget.

Funding never affected the character of JSA. We didn't take funding just for funding. We were very mindful of the "money not dictating". That level of caution needs to be maintained. There has to be a strong will to manipulate to our advantage.

At the regional / global level

Most respondents were not aware of funding sources of PHM at the global level nor the activities or campaigns for which they were received / sought. Of those who were aware, one activist said,

There is urgent need for funding for global programmes. We need to channelize funding for movement building. There is very little money and if it has to be distributed widely then the amount available to each is very little. We need to be strategic and use money for processes that lend to getting people to come together.

Achievements

- Responses about achievements highlighted the many activities, campaigns and issues that JSA has been engaging with in the past decade.
- JSA is highly visibile. Members of JSA are invitation by the government regularly to be part of committees to plan, review health programmes and policy. However, one of the activists also expressed that most often, there was no information on who from JSA had been invited and sometimes identities – of organizations are put prior because they are not in a position to represent JSA as there is no clear position or because there has been no collective deliberation.
- In some of the states where JSA is active, it is seen as an important actor in facilitating change.
- JSA is perceived as a very important entity that needs to be strengthened and must play a significant future role.

Challenges and Recommendations

- JSA is usually unwilling to review organizational issues and processes. A review process was planned last year but there has been no move forward on that front.
- If the movement needs to be strengthened then we need a national vision, multicentric mobilization on key issues. Wider mobilization of different sectors – trade unionists, nurses / health providers who are sympathetic and agree with JSA principles, etc. is critical.
- Steering committee needs to communicate proactively, clarity about the roles, composition of the PHM SC is also necessary. The process is not very systematic and transparent right now. If there is a country representative in the SC, clarity / transparency about the process followed for selection, participation of JSA governing structures in selection process and regular feedback by the representative is necessary
- JSA has played an important role so far but there should be more grounded voicing of issues – wider grassroots mobilization is a must. Does the PHM want to reach only organisations or also reach the people directly?
- The use of JSA opportunistically was also raised as a major concern. Some respondents were concerned at the non transparent nature of engagement by JSA members in PHM global and at the national levels, of processes and initiatives without the knowledge of other JSA members and activists.
- Similarly there needs to be clarity on processes prior to someone / anyone representing JSA.
- Rotation and review of those who are part of the governance structure – convenors as well as organisations.
- Accountability mechanisms need to be put in place for all who are part of these structures.
- Although JSA /PHM talks about social determinants but there is not enough support for campaigns for determinants in India.
- Review of structure at the national (JSA) as well as global PHM should be undertaken to ensure diversity and inclusion.
- To ensure that PHM principles of diversity and inclusion are followed while upholding the autonomy of a country (in the region) or state, a system of review between countries in a region or within the country (India) should be undertaken at regular intervals. This could enable interlinkages and peer pressure to ensure that principles are followed. Broad democratic principles can be provided.
- PHM is very visible in some areas – as in the WHO. There is no information about the PHM in different countries – no information and skewed view of PHM
- A record of JSA in all states as well as PHM countries, particularly in the region, their structures, activities would be very useful to create linkages and strengthen campaigns on common issues. This could be facilitated by the secretariat (JSA national and PHM global).
- National secretariat needs dedicated persons – past experiences have shown that if JSA plans national level campaigns in addition to ongoing activities for mobilization then at least two persons are required.

Appendix 11

PHM in Thailand (2011)

Thai Context

Thailand is a country with relatively good health statistics and an extensive health infrastructure. Since 2002, it has adopted and implemented a policy of universal health coverage with a substantial Primary Health Care focus. In 2007 the National Health Act, developed with strong public participation over a period of seven years, came into force. This Act gave birth to the National Health Commission which is assigned "to support the development of healthy public policies in cooperation with various sectors in the society"[50], placing the well-being of the people at the center of their attention. The National Health Commission Office (NHCO) was set up to provide secretarial functions for the National Health Commission. It is an autonomous government organization that falls directly under the Prime Minister of Thailand. It works with all sectors and combines representatives of government, academics, health professionals, civil society (or "people sector") and the private sector. About one-third of the National Health Commission members are from civil society.

> *"It is good to include someone from the private sector, so they start to realize what the effect is of what they do."* (friend of PHM, Thailand)

In accordance with the National Health Act, annual National Health Assemblies (NHA) take place which provide significant opportunities for constructive dialogue among all stakeholders related to health in the country. The NHA resolutions are submitted to the National Health Commission for action and, if necessary, submitted to the Cabinet.

> *"The idea is to link the 'political power', the 'social power' and the 'intellectual power' to form 'the triangle that moves the mountain'. This is a tripartite powerful strategy to achieve long term and sustainable implementation of participatory healthy public policies."*
> (NHCO website[51])

PHM connections with Thailand

A limited number of Thai delegates participated in the first People's Health Assembly in Savar, Bangladesh in 2000 but it was not until the second People's Health Assembly five years later that interactions with PHM (Global) became more regular. A delegation of eight people from Thailand, from government, NGOs and academics, participated in PHA II in Cuenca after being invited by PHM to attend.

Since that time, PHM (Global) was invited to two of the three National Health Assemblies organized in Thailand and to the annual Prince Mahidol Award Conference. At all these meetings, several PHM (Global) representatives attended and took active roles in organizing, presenting or facilitating sessions.

There has been some communication in the past between the PHM Regional Focal Person and the Thai focal person, but this has not led to any concrete action or clear support. Most of the communication takes place directly with the Global Coordinator and this is appreciated and considered effective.

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[50] http://en.nationalhealth.or.th/Background (accessed 20 June 2011)
[51] http://en.nationalhealth.or.th/nha2010 (accessed 20 June 2011)

PHM Identity in Thailand

According to PHM connections in Thailand, there is no actual "PHM Thailand" or Thai Country Circle for PHM in existence. Because most of the current connections work in the NHCO and are therefore part of the government, they feel they cannot identify as PHM rather as 'friends of PHM'. NHCO's website mentions PHM on its partnerships page.

Some efforts have been made to identify a non-government entity to take over the coordination of PHM Thailand, but this has not been successful yet.

> *Many NGOs in Thailand already have their thematic counterpart at international levels. For example, Consumer groups have Consumer International;, women's health groups have international women's health networks and organizations; local disability groups have international disability organizations and networks. The added value for them to be part of PHM is not clear.* (PHM Focal Person Thailand)

There is not a specific NGO with a mandate like PHM's who could easily be the national counterpart and coordinator for PHM in Thailand, although many NGOs are active in areas that strongly relate to PHMs mission such as women's health, social determinants to health (the Social Inequity Reduction Network), consumer protection, community strengthening, informal labor and health impact assessments of mining activities.

Relevance of PHM Asia

There is not really a PHM Asia, and from the Thailand perspective there is no need for it as that could lead to 'bottlenecks' in the communication with PHM Global. ASEAN is the regional government platform for South East Asia but it allows very limited access from civil society actors. Instead, it is more effective for PHM to lobby national governments, linked with the global lobby that is already ongoing.

NHCO does intend to work more at regional level including with ASEAN, WHO, and issue based networks. Collaboration and exchange between countries in the region is very limited, and this might an area that could be improved. It is useful to know about good practices and share evidence between countries from a people's perspective as opposed to only the academic studies that are more easily available. At the moment PHM-Exchange partly fills this gap.

Relevance of PHM Global

> *PHM has a clear role, relevance, and recognition at global level.* (PHM Focal Person Thailand)

Many of the global initiatives of PHM are considered useful and interesting, but often not really relevant for Thailand as it is a relatively developed country. Take the Right to Health and Health Care Campaign for example, the use for it in the Thai context is not clear to the PHM contacts in Thailand. There has been an attempt to get an IPHU course to Thailand, in collaboration with a university in Chiang Mai, but it is difficult for people in university jobs to have enough flexibility in their job to be able to include such a course. The option of sending Thai people to IPHUs in other countries needs to be further explored, although language and funding would pose a challenge.

PHM's work with the World Health Assembly (WHA) is considered a useful exercise that could lead to tangible results. Thailand used to only send government officials but now has included other sectors such as NGO, media, private sector and health professionals from rural areas in the delegation. NHCO sends its network as a part of the delegation every year.

Also the Global Health Watch is highly appreciated. Thailand has contributed to previous Global Health Watches and there is some initial thinking taking place to make a Thai alternative health report.

Ways forward

The PHM Focal Person in Thailand would like to see a new Focal Person identified who can take PHM forward, as he cannot do that in his current capacity working for the government. Perhaps someone can be identified through IPHU if more Thais can participate. Thailand is very much interested in PHA III plans for 2012 and would like to take an active part in it in terms of agenda setting, and sharing of good practices like community based health impact assessments that have been successful in Thailand. Further suggestions to PHM Global are to organize thematic discussions (moderated e-discussions for example) for which people can sign up to participate.

Appendix 12

Current PHM Global Secretariat sites with their division of labor:

Location	CAPE TOWN	CAIRO	DELHI
Led by	PHM Global Coordinator	Previous PHM Global Coordinator	GHW-3 Coordinator
Hosted by	PHM South Africa	The Egyptian Foundation for Health for All	SAMA
Main functions	-Main PHM Global Secretariat - Overall coordination - Support to movement building (with focus on Africa) - Promote PHM visibility - Support Right to Health Campaign - Technical and administrative support to PHM campaigns and issue based circles - financial management - good internal governance and decision making processes - Organisation of PHA-3	- Coordination of IPHU -Relation with the WHO - PHM communication including website support - Mobilizing resources and fund raising	- Coordination of GHW-3 - PHM Liaison with global networks and fora including World Social Forum (WSF) - Policy Resource Development - Budget Tracking
PHM posts	-Global Coordinator (full time) -Liaison with African country circles (part time) -Accountant Administrator (parttime)	-PHM Associate Coordinator -Communication Officer -Web developer -Accountant	-GHW-3 Coordinator -Research assistant -Administrator